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of the

Maine Medical Association

MAINE MEDICAL ASSOCIATION

The Ninety-First Annual Session will be held at the

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1. MARSHALL, S. F., and DEVINE, J. W., Jr.: Gastrojejunal Ulcer, S. Clin. North America, 743-761 (June) 1941.

2. FAULEY, G. B.; FREEMAN, S.; IVY, A. C.; ATKINSON, A. J., and WIGODSKY, H. S.: Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med. 67: 563-578 (March) 1941.

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*A Social Obligation of the Physician**

E. Eugene Holt, Jr., M. D., Portland, Maine

During the past ten years an economic change supposedly favoring the forgotten man has been promulgated by a philosophy somewhat foreign to our experience and called the "New Deal." Under the guise of a war emergency measure a socialistic element in Washington, with the blessings of the higher-ups, has been quietly evolving ways and means to "shang-hai" the practice of medicine; to speak more plainly—to make the care of the patient a political football. This is just what the Wagner-Murray-Dingell Social Security Plan proposes to do —the Vicious Bill 1161 (HR 2861).

The bill, as proposed, would be administered by a politically appointed Surgeon General of the Public Health. In the appointment to this political plum with practical control of three BILLION dollars, more likely the choice would be influenced by political implications rather than medical knowledge and ability. The bill further provides that the Surgeon General as Chairman should select a council of sixteen from a list of physicians and agencies informed on the need for or provision of medical benefits. No mention is made of the number of physicians and the chances are that they would be in the minority. That the advice of the council is of enough importance to be followed by the Surgeon General is not even mentioned. In reality a puppet council is thrown in to delude us into a false sense of security.

Thus the provisions of this bill would create a Czar—The Surgeon General of the Public Health, politically appointed, given the power and finances to regiment and regulate the whole medical profession. Would you relish, or do you think such an individual would be qualified to judge your professional standards, establish your rates of pay or fees, and determine the number of patients you may provide service and designate the hospitals and clinics available for such service? Who could blame us for rebelling against such a set-up?

The hospitals have not escaped their clutches—the bill proposes a maximum rate of $6.00 per day to include all services for the first four weeks and thereafter the rate is reduced to $3.50 to $4.50. It is doubtful if the maximum rate would be paid. By no stretch of the imagination could the govern-

* Presented at the annual meeting of the Portland Medical Club, Portland, Maine, December 7, 1943.

ment possibly give the same type of service with the present financial arrangements. What would be the service with reduced rates? It would seem that such an outrageously low rate is offered as a means of destroying the present voluntary hospital service so that the government could assume control of the present hospitals in this Country. This would mean the end of voluntary hospital service. The extra burden undoubtedly would entail an expenditure of a larger sum of money than anticipated, thereby requiring increased taxes to meet it. The public would be forced to pay a tax of 6% on incomes up to the first $3,000 a year, and a tax of 6% would be levied on the employer for every employee; but the indigent who are the most in need of medical care and hospitalization are left out in the cold.

That this bill has teeth in it to accomplish its purposes—the complete control of the free practice of medicine and the present system of medical education and voluntary hospital service cannot be denied, as it is in plain language throughout the sections of the "Federal, Medical Hospitalization and Related Benefits" of the bill. Such a bill if enacted would shackle the science of medicine and thereby spell doom to all of us; and would be a heritage unworthy of this great profession!

A revolution of this kind might be justifiable provided medical education and the practice of medicine and hospital service had sunk so low as to constitute a National Emergency under the American System. American medicine and our medical schools and hospital service, voluntarily organized, are giving our people better trained physicians and better hospital service than any other nation enjoys. There are no doubt areas where much needed medical care is lacking, but this should not serve as an excuse to radically change the whole system of medicine. This socialistic group believe that socialized medicine is based on the assumption that government, particularly Federal Government, is always efficient. But today while the Federal Government has unprecedented authority and huge sums of money to work with, we are seeing how a vastly expanded bureaucracy works. We are being shown that bureaucrats are far from being paragons of wisdom and proficiency. We could guess what would happen if all doctors were incorporated into a Federal bureaucracy.

Thus the provisions of this bill have created widespread discussion from which some concerted action has developed. I cannot conceive of any difference of opinion on such a radical change in which our freedom and liberty in the practice of medicine and hospital service are threatened by such a crowd designing for power and more power!

What are the means at our command and how can our efforts best be utilized to combat this unfortunate and I believe undeserved ever-present danger. This depends upon the attitude of the profession. The physician cannot ignore this issue thereby allowing it to gain momentum, but rather must act intelligently to convince the public and Congress that the medical profession is unwilling to give up to the politically minded bureaucrats, but they are willing and anxious to help solve this problem in a free way; that is, in the interest of the patient, physician, hospital and government. The study of a committee of the New England Medical Societies has resulted in the release of a letter which has been accepted by the State Associations and approved by the Council on Public Relations and Medical Service of the A. M. A. and the Editor of *The Journal of the A. M. A.* This open letter* is to be sent by each of the New England Medical Societies to their respective representatives in Congress. Also the letter with editorial comments will appear in the December 11, 1943, issue of *The Journal of the American Medical Association.* In addition Dr. Michael Tighe of Boston, Secretary of the New England Committee, has been able to make this open letter available for publication in 500 Farm Journals located in the far West. One of the recommendations of this committee is the advocation of a long-delayed establishment of a National Department of Health with a Secretary in the President's Cabinet, to coördinate the many important health programs.

The National Physicians' Committee has

* Published in the December issue of the JOURNAL.

been active and recently has distributed a pamphlet on "A Symposium—Comment and Opinion on Political Medicine in the United States."

Hon. Joseph W. Martin, Jr., of Massachusetts, Republican Leader of the House of Representatives, in an address before the Medical Society of the District of Columbia on October 1, 1943, decried socialization as an entrenchment of bureaucracy to achieve permanent personal power, and strongly voiced his opposition to bill 1161.

Much valuable assistance also has been given by the Press throughout the Country warning the public in their editorials of the dangers of such enslavement.

At a Meeting in August, 1943, the American Bar Association condemned this proposed legislation.

Most of the hospitals throughout the Country have expressed their protests to legislation of this character, as have many lay organizations such as Service Clubs, Chambers of Commerce, etc.

The public should be interested and perhaps easily convinced of the dangers of such a program as all, even the wealthy, would be regimented into medical care and hospitalization, the one exception being the indigent. The citizens would have to foot the bills—a payroll tax amounting to 6% for a new and expanded Social Security program. This means that the working man and his family must face an extra medical burden for a medical service not of the kind now known, but for a service that is bound to be of a reduced standard. In other words, he will not be getting his money's worth. In addition, the employer's end of the tax would inevitably increase his costs and the workers would have to pay proportionally more for what they must buy. Yet this bill has the blessings of the CIO and AFL and the approval of a Gallup poll.

Already in many states a prepayment health insurance is in practice, the first being in California in 1939. This health insurance offers a means in giving the kind of service outlined in bill 1161 in a voluntary way at a lower cost. The growth of this form of insurance has had its obstacles but has been steady, encouraging and healthy. This type of medical service really is an outgrowth of the "Lodge Service," part of which was sound but more was cheap and of a poor variety.

The Massachusetts Medical Service was explained by Dr. McCann,** of Worcester, at a Council Meeting in October. The plan operates in conjunction with the Massachusetts Hospital Service and is under the supervision of the State Department of Insurance. It is a non-profit organization, was started January 1, 1943, and has been approved by the Massachusetts Medical Society. The management and policies are controlled by a group of qualified physicians. All administrative arrangements are handled through the Massachusetts Hospital Service. The Medical Service is limited to surgery and obstetrics. On incomes less than $2,000 (or $2,500 for a family subscriber) the benefit received is without regard to cost and in addition medical consultations in major surgical cases up to $15 are provided. On incomes of more than $2,000 (or $2,500 per family), the benefits are limited. Payments of specified amounts in the fee schedule are made by the Massachusetts Medical Service to the physician, and this payment is credited on the full charge which the attending physician is free to make as he would in a non-subscribing case. There are fee schedules for 550 different conditions under which a subscriber is eligible to receive benefits. The fee for an appendix operation is $75 and an uncomplicated obstetric case $40. The rates per month:

Individual	$ .85
Husband and wife	1.65
Family, including husband and wife and all unmarried children under 19 years of age	2.00

Enrollment of the employee and family does not require an examination, regardless of age. Subscribers are enrolled in groups through their places of business and payments are made by payroll deductions. Dr. McCann especially emphasized the help and coöperation of the Blue Cross plan, and he believed that any contemplated plan should take advantage of such valuable service.

** See Dr. McCann's address to the Council, published elsewhere in this issue.

This Massachusetts Medical Insurance Plan to date has shown a profit and the indications are favorable for greater expansion. The number and professional standing of the doctors signing contracts with this service is large and gratifying.

The Council of the Maine Medical Association, at the October meeting, was faced with the fact that socialized medicine is knocking at the door. Two alternatives presented themselves: Should nothing be done, thereby allowing socialized medicine to be developed by the laymen and designing politicians; or should an attempt be made to offer a program voluntary in character to serve as a beginning to render the kind of medical service familiar to us all and under the control of the medical profession? The Council chose to try a medically controlled method, and appointed a committee to formulate a plan of non-profit medical insurance in Maine. The development of any plan as important as this requires considerable study and consequently must necessarily be slow. The Committee has the advantage of the experience of other plans in operation and no doubt in the beginning will offer a limited plan which should be flexible so that it can be broadened to include the very low income and the indigent groups and a medical service of the whole body. These changes are desirable and eventually can be accomplished without radically altering our social patterns. That there will be opposition to this plan is to be expected, but this should not be serious if these alternatives are kept in mind: Federal Control of Medicine—or—Medical Control of Medicine. To put the question bluntly: Would we fare worse under politicians or under our own control? Criticisms of the various sections of a plan are expected and if given in a conciliatory and coöperative spirit, should contribute towards perfecting a plan that has a better chance of success. This Committee, of which Dr. John O. Piper of Waterville is Chairman, I am sure will welcome criticisms which will contribute towards the success of a medical insurance plan now being considered. At present all plans are far from perfect, but with more experience the imperfections will be eliminated, and eventually the aim to provide medical care for the indigent will be accomplished with aid from various existing agencies and perhaps the Federal Government. If the Federal Government really is desirous of helping in giving better medical care and hospitalization, this help should be given in the areas where both are lacking, under the existing conditions. They should further supplement all voluntary efforts in supplying medical care and hospitalization.

Prepayment Medical Insurance offered in conjunction with the Blue Cross Hospital Service would appeal to the public more than either one alone, would fulfill a much needed want, and would be acceptable to the Hospital Group.

The proponents of this bill are alert and cunning and are hoping for a divided profession while exerting politically every effort for its passage even if amended. If this bill in its present form, or anything like it, is adopted, the question might well be asked—What are the aims of the present war? Are they to set up guards supposedly against want of medical care by enslaving the Medical Profession and Hospital Service and depriving the people of their rights to choose their own physician? Is this the magic social pattern to be followed in giving us security from the cradle to the grave? What a disappointment would be awaiting the returning medical man who has sacrificed so much for the right to return to the pursuit of his chosen profession — the free practice of medicine—his reward for years of endeavor and devotion in the field of medical science.

The Medical Profession cannot sit idly by and watch the present system of the free practice of medicine disappear. They must accept this challenge with a united front and they must *lead* in the development of measures to meet this changed economic condition. The Hospitals through their Executive Boards and Directors of the Blue Cross Hospital Service and all other agencies must be encouraged to continue the invaluable service already given. Their service and influence has helped immeasurably and will continue to help in opposition to any legislation of this kind.

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*Prepaid Medical and Surgical Care**

James C. McCann, M. D., Worcester, Massachusetts

Mr. Chairman and Gentlemen of the Council: It was very kind of you to ask me to come to talk on this matter with you. I have had the pleasure of meeting a group of your representatives before in Boston. But aside from an opportunity to discuss this matter, in another way it gives me great pride to feel that I have been asked to come back to Maine to speak. I hope if I can give you a little something to start you forward, it will pay back slightly my great indebtedness to my father who practiced among you; Daniel McCann, M. D., of Bangor.

A good way to look at this problem is on the basis of two simple questions. First, why, and second, how? We are all groping in this field, and I think that if a State like the State of Maine has not yet embarked on such a program you may now find yourselves faced with the necessity of doing so. But any group of intelligent men will ask themselves, why should we do it? The answer, of course, has many angles and is disputable.

We are all so propagandized today that when a man like myself has something to say, we ask if he is doing it on a partisan basis or is he trying to put something over. To place myself, I am just a practitioner of surgery in Worcester, Massachusetts. I was simply put on the medical care committee to represent the central part of the State of Massachusetts. When Dr. Lanman, the Chairman, went into the service I was made Chairman in his stead. I went at this task without any prior convictions whatsoever. So that I think you may feel that such experience as I shall describe to you isn't based on any preconceptions or prejudices.

Now certainly this work has been a great education to me. We are all so busy doing our day's work that there are many aspects of medical care with which the average physician is unacquainted. We appoint men from the society to investigate and tackle certain specific problems. Much on this basis is accomplished by our medical societies and it is accomplished by the men who are pulled out of hard daily practice. Of course we are widely criticized for what we do on all sides, but we always have been and always will be. We only can do our best sincerely.

I. Why?

Now let us search the first problem of the need for such a program, the answer to our first question, why. I think we should look at the situation from the angle that we are in a profession which deals with problems that have a broad public relations aspect which will be subject to control by the people in some way. This is shown by the state care of the tubercular and the state care of the mentally ill.

Now for the last ten or fifteen years people outside of the profession have insisted that there are medical needs yet to be met. The profession as a whole was a little slow in accepting this thesis. Certainly speaking for men who are in the middle passage of life we, as a group, admit that there are problems to be met. Within ten or fifteen years our medical problems will be met by the next oncoming generation of physicians. I don't know what the next generation will do about them, but the handling of current problems are best left to each generation of physicians as they come along. This problem of prepaid medical care is being handled by men of my medical generation.

We accept the existence of a problem which breaks itself down into two phases; first, the distribution of medical care and secondly, the cost of medical care.

Regarding the problem of the distribution of adequate medical care, there are three major studies which should be impressive to us all. The first is the study by the Committee on the Cost of Medical Care. There were two recommendations, a majority and a minority recommendation from that study. That was simply as regards to recommendations, however. The basic findings that came out of the committee study was that there were problems relating to the distribution and cost of medical care. The heart of the problem, as their summary stated, is the cost of medical care. The second important study was the survey carried out by the Ameri-

* Presented at a meeting of the Council of the Maine Medical Association held Sunday, October 24, 1943, at Rockland, Maine.

can Foundation. Questionnaires were sent to men like you and myself. I know the men who received the questionnaires and I know what their answers were. One cannot look through the two published volumes without discovering that the men at large in the practice of medicine recognize that there are problems to be met. Stimulated by the report the so-called Principles and Proposals were published and were sponsored by a small group of physicians principally connected with the schools. Their very broad principles were open to such radical application that the profession at large was distressed by their nature.

The third survey was done under the auspices of the American Medical Association. The interesting thing to me is that the American Medical Association as such wanted to prove what the problem was from the viewpoint of the physician. The headquarters at Chicago received reports from only 38 out of 48 states. In addition each state had only a restricted number of counties which reported out of the total number of counties. I headed the survey in my county so I know what a task it was to accomplish it. There were serious questions in the minds of the physicians in Worcester County regarding the distribution of medical care and the cost of medical care. I don't think from all this that a blunt denial could convince the men of my generation of the non-existence of these problems. We can't shrug our shoulders and say that there is no problem.

Now with regard to the cost of medical care. I have the advantage of perspective on the changes in medicine from having had a father in the practice of medicine. I know directly what have been the many changes. The cost of surgery and obstetrics was nothing in his early days compared to what it is today. Many conditions are hospitalized today which were not in those earlier days. The diagnostic procedures which are carried out today are immensely valuable but costly for many many people. Laboratory work is extensive and costly. In the roentgenolotic field I think we have only to see an $18,000 piece of X-ray equipment installed and know that it has got to be replaced some day to become acutely aware of this problem. Biologicals are expensive and widely needed. Then to carry on the profession, to supply many men highly equipped and trained in all fields, and to see that these men are compensated adds to the problem of growing costs in medical care. All those factors have certainly created in my mind a problem regarding the cost of medical care. In many of the points I raise I shall use the words of others to support me. In a recent address, James A. Hamilton, past president of the American Hospital Association, said, "As scientific progress continues, therapy becomes increasingly expensive. The incredible cost of merely producing enough penicillin for a single patient is an example, though, of course it may later be possible to synthesize this 'miracle drug' for much less. But the fact remains that even after the war, the cost of first-rate medical treatment will slowly climb."

That is a fact accepted today by the public; we must act today on that fact. It is becoming clearer to the whole profession that if we don't act ourselves, someone else will. We may lose what we consider some of the basic rights of our profession, if by default we allow the solution of these problems to pass to other hands.

I have been very much impressed as I follow the statements of Eric Johnston, President of the Chamber of Commerce of the United States. He says, "If private industry can't supply employment at reasonable wages, of course the government will." That may be paraphrased to apply to medical care. Business men of America are looking for the values they hope to conserve and are acting to save them. We should do as much for medicine. If you want to know the basic differences between England and America, so far as it throws light on the different attitude of the medical profession in the two countries, I suggest that none of you miss a recent report in *Life* magazine. Eric Johnston and a Mr. Benton went over to talk to the English business men. England, they learned, is not so much interested in the individual and in private enterprise, as it is in looking to the role of the state in producing security in a state planned economy. The Englishman so accepts monopoly that he would like to see us repeal the Sherman Anti-Trust law. Remembering what Johnston said with reference to private employment, I think we can take his statement as a forecast of what is going to happen to medicine if we fail to solve the problems confronting us. If we don't do something the Government will. Now when you survey what

has already happened you will realize that the government is paying for the education and the training of doctors. Extension of Public Health Service is significant. Where there is a shortage they have undertaken to send Public Health men to the communities to practice. There are large bodies of men coming out of medical school who will have been trained and educated by and under the government. They will never have had any experience in private practice. They will only have been on salary from the government. What will be the attitude of these men in the future regarding "free enterprise" medicine. They may say it is necessary and easier to go on under the government. If we don't do something to solve current problems, they won't take our word that the government should disregard them! We are not going to force our opinion on these boys at all, and we have got to do something to persuade them that the profession can solve the problems which confront it.

The extent to which the Federal Government is involved in our national life is great and has a bearing on its extension in the health field. To quote: "While the government was putting $15,000,000,000 into the building and expansion of manufacturing plants, business was investing $4,000,000,000 for the same purpose. With private industry's net investment in manufacturing enterprises before the war figured at close to $51,000,000,000, this additional $4,000,000,000 increases the total to $55,000,000,000. The government has $15,000,000,000 out of $55,000,000,000." How far will the government retract from it's extension in the economic field after the war? And from medical care?

Industry under a few men is encroaching on the field of medical care, charging the profession with inaction. Henry J. Kaiser has a non-profit health program, at his California plant. To quote: "Henry J. Kaiser's controversial non-profit health program for the care of his 70,000 Richmond shipyard workers ended its first year with a record of 838 major and 4,652 minor operations performed. Participation in the program is voluntary, and each employee who subscribes pays 50 cents per week from his paycheck for unlimited medical and hospital care. Workers were treated in a $500,000 hospital built by Kaiser and staffed by 75 doctors, many of them young Stanford Medical School graduates, who were paid $450 to $1,000 a month." Young, well-trained doctors went in, which is a fact whether we like it or not. Kaiser has taken a unique problem and met it. It can't be applied to industry in Worcester county. Furthermore, I haven't heard of Mr. Kaiser's doing the same in the Brewster Aviation Plant or in one of his industries which failed according to *Time* magazine reports. There is always this major problem, can such a set-up be carried through a depression era? Endicott Johnson was on the verge of dropping their medical program during the depression as I know from a friend who worked there, but it was not publicized. That is not a solid basis for medical care.

Then there are labor unions which are starting to undertake group programs in medical practice. They haven't developed largely, but they are powerful units which are asserting that they have something to say about medical care problems. If we let the whole thing go they will say something as proved by the current Wagner-Murray-Dingell bill.

Consumer coöperatives represent another threat. We, in Massachusetts, faced it with the White Cross Group, a consumer coöperative fathered by five physicians headed by Drs. Frothingham and Cabot. We, in the State of Massachusetts, felt that it wasn't for the best interest of the profession to become legally involved as had the men in Washington, and the officials of the American Medical Association. That episode was based on the fact that in the city of Washington where an industrial smoke stack cannot be found, the medical society said to physicians, "if you wish to remain a member of this association our committee has got to read and approve your contract. If you reject our stand on the contract you are out of this association." If a small group of physicians in our industrial State of Massachusetts undertook to tell any man that they disapproved their contract, they would be laughed out of the society. Yes, we made no such mistake in Massachusetts. I, at the time, was active in a group which dissuaded the physicians from taking any action against these five men. The White Cross and other such propositions usually fail of their own errors. That was the fate of the consumer coöperate movement in Massachusetts; there is no substance to their face-saving assertion that

they suspended because idealistic young men are in the service. One involved man in Washington told us not to do what they did. They admit they made a mistake in drawing in the American Medical Association.

In addition to the consumer groups there are the prepaid medical groups. You all know of the Ross-Loss group in Los Angeles, and the Trinity Group in Arkansas. I don't think these other groups will be permanently very effective over a large segment of the population.

What is prepaid medical care based on? It is based on an effort to find a less expensive way for the layman to pay for medical care. Some men are confusing prepaid medical care with group medicine. The two problems must be kept apart. One interesting thing I encountered as I went around to the various county societies to present the state program was that I had to wait while the doctors discussed a medical insurance program for themselves. If the doctors find it to their advantage to carry medical care insurance how can we tell the public it isn't to their benefit to do likewise. No one can question John Public if he insists on this right. There is no question in my mind that if we do not make payment for medical care available on a prepaid basis, then the government will do it on a tax basis, for John Public.

We are caught inevitably in the current drama of American life, both economic and political. We are caught in two major conflicts which can't leave medicine unaffected. First is the conflict between the centralization of federal power versus the preservation of traditional American freedom. The second current is the limits that are to be placed on free enterprise versus government regulations in the provision of social security as related to old age, unemployment, and illness. We are caught in the last item. Whatever happens to us will be determined by what is done with reference to these basic currents. I think the answer will come from those 10,000,000 boys in the service. I think it is vital to make them feel that we can handle this thing. We have got to show them we have an answer. How can only 150,000 doctors out of 130,000,000 people handle this matter on any other basis than commanding their confidence in our ability to cope with the problem. If we fail in persuasion and demonstration, we are lost!

We are committed to a desire to preserve freedom of enterprise in medicine as business wants it, and as labor wants it. Green, President of the American Federation of Labor, rejected linking labor to the Russian trade union group when he said, "We are a little apprehensive and fearful that we might through the development of relationships with others who are not free, find ourselves subjected to governmental control and governmental domination, and no worker in America wants that." No doctor in America wants that. The spirit of fair play has always been uppermost in American life and will lead people to see that doctors likewise are entitled to freedom. We must, however, acquire as much idealism in this matter as are the men in business who are going to form the post-war business world. I don't think anyone is going to have more to say about making that business world than Stettinius. As Stettinius has declared, "There is today a new rising tide of aspiration to conduct our instruments of production with more statesmanlike emphasis on the welfare of all involved. This is as natural and inevitable as the ebb and flow of the tides." I think that that can be reworded to apply to medicine and medical care.

The conservatives in the business and political field admit that there are problems. Governor Thomas E. Dewey, of New York, predicted "a post-war expansion of social service in which voluntary and governmental services and agencies will coöperate to heal the heavy scars that the state and nation will bear both spiritually and physically after the war."

Vice-President Henry A. Wallace made a statement which may well be applied to medicine. He said that "free private business must accept the responsibilities inherent in free enterprise" or face "the increasing use of governmental agencies to assume this task" in the post-war period. These problems in medical care are our responsibility, and we must meet them if we wish to live on a free enterprise basis.

We are in a unique position. We are not a complete monopoly, but there are definite restrictions on competition in the field of medical care. There are only 5,000 new doctors turned out a year to maintain our approximate total of 150,000 physicians. If a physician charges a patient more than he should have in fairness,

competition in medicine isn't so unrestricted that new physicians are going to spring up over night to compete with him. We have got to think in terms of that earlier status of physicians. We have got to assume the responsibility in handling special problems inherent in this unique status of physicians. Willkie said in a speech at St. Louis, while discussing free enterprise, and we probably must apply it to the medical profession, "Where enterprise, whether by necessity or by default, excludes competition, such enterprise must be regulated in the interests of the people."

Now we are faced today with a very concrete threat to our free status in the Wagner Act. It embodies everything which we have dreaded. One man will become a Czar of Medical Practice. Government may say you will or you won't be free to do this or that in the practice of medicine. You all know the threat. To meet such threats we must have both an offensive and a defensive plan of action. Our defensive action consists merely in finding our natural allies and bringing enlightenment to Washington of the dangers inherent in such plans. One of our natural allies is the hospital group. They want to remain free as we do; so does business; so does the organized Blue Cross. As a large group we must oppose this move towards socializing the whole health structure. On the offensive side it is to your best interest to organize medical care as we are attempting to do in Massachusetts. If we undertake to solve these problems which confront us I think these other groups will come along with us. They will learn to see that what threatens us will be brought to bear on them. We have got to interest them in supporting our effort. It is no longer one fellow for himself; the groups must be of mutual help to each other.

I was tremendously impressed several months ago when our state medical care programs had a meeting in Chicago to have Dr. Leland, of the American Medical Association, stand up and in the course of his discourse say that it is no more possible to stop changes in medicine and hold it as it now is than it is to stop the sun and check it in its course. It can't be stopped and neither can changes in medical organization. If we want to conserve for medical practice its basic values we have got to guide the inevitable changes. Not to do anything is to let all go by default. Default is fatal. I, and many of you here would undoubtedly end up by practicing under the government if we do default.

II. How?

The second question is, how? First, there must be a decision by the medical profession to undertake such a program and to support it and the men who put it into effect. Before this is undertaken the state medical profession at large should and must understand these problems. The state society as a whole must undertake the program, and not permit county action. We undertook the problem by printing and distributing material to all physicians in the State. Physicians are busy and only a few will get to the county meetings to hear discussions of the problems. The others are sufficient in number so that if they are not instructed and aren't persuaded they will make it difficult to initiate a program successfully. Having come through this phase I stress the fact that it is vital to have the thing done by the state society as a whole, without separate county action. This has been made a source of difficulty every place it has been done. If such a program is to succeed it must be done on a state-wide basis. If the profession as a whole is in back of it, I don't see why a few men in any county should jeopardize a program by arbitrarily keeping it from the people in their county. In New Jersey they allowed county review and now New Jersey is feeling the handicap of it definitely.

There are several problems involving basic matters of principle which must be wisely handled lest you enter a dark passage. They are: 1. Passage of an enabling act. There are two very important problems determined in the enabling act. First, the supervision of the program is determined. Most states, including Massachusetts, have placed it under the supervision of the Insurance Department. We grant that they don't know a great deal about medical care problems, but we will accumulate money in large amounts to be handled by us for the public. Only the Insurance Department is qualified to supervise this basic matter. There are those who think such programs should be under public welfare. Second, the enabling act establishes qualifications of physicians who participate. We have accepted the viewpoint that any man

licensed to practice medicine by the State authority should participate in this program. It is vital in drawing up your enabling act to make it in general terms and not to be specific with this detail or that detail. Otherwise you will find that you will have tied yourselves up and that any errors can only be corrected by another act of the Legislature. Don't let the language be other than general in your enabling act or you will live to regret it. Solve your specific problems in the by-laws which can be changed with permission of the Insurance Department; or by rules and regulations which can be changed by the trustees.

2. Formation of your corporation. You will establish two groups; the voting members of your corporation, and the board of directors. In one group or another you must conserve adequate powers to the profession to provide that you will not get violent changes from your present mode of practicing medicine. You have got to draw up your organization very carefully. We have our voting members made up of members of the Executive Committee and Officers of the Medical Society. They elect directors and change the by-laws. Our Board of Directors is composed of one-third physicians, one-third representatives of the public, and one-third outstanding eminent laymen. If anything radical were to be undertaken by this board the voting members have sufficient power to stop it. This gives a generous representation to the public and the profession is adequately protected against unwise departures. We have broken the board of directors down into committees to function satisfactorily. There is the Central Professional Service Committee made up of the doctors, the Financial Committee, the Executive Committee, and the Research Committee.

3. Economic background for the program. You have got to look at your state picture, to plan your program. The State of Massachusetts is urban 86%, rural 13.9%, rural-farm 2.9%. Our urban areas have many moderate-sized industrial units; Boston has many moderate-sized trade units. They must be sold in groups. In Michigan they have enrolled half a million people. They can do this because they go to General Motor or to Chrysler or the others and they will throw in 100,000 or more employees. Compare this to Massachusetts where a very restricted number of industries (44) employ over a thousand workmen. It will mean a hard job to sell the program in comparison. Growth will be slower. It will be slower in the State of Maine where you don't have as large industrial units as we have in Massachusetts.

4. Income limitation. Most plans establish income limits for service contracts. A service contract means that after the physician has signed a contract he agrees not to charge a cent more from a patient for any service, than the corporation allows. Anybody with a contract who has an income larger than the specified limit holds the contract on a cash indemnity basis, and the physician is free to charge more than the allowance from the corporation. My frank opinion is that with an experimental program of this type you cannot persuade the profession to go along with it on any other basis than that of income limitation for the service contract group. In two years, with income limitations, Michigan sold 500,000 medical care contracts. They have sold just as many medical contracts with income limitation as the Blue Cross in Massachusetts have sold hospital contracts without income limitation. I just give you these different aspects of the problem. It is a difficult one. We have set as a limit for service contracts, $2,000 for individual, and $2,500 for families. A family with several children ought to be eligible up to at least $3,000. As a practical matter labor draws the line between workmen and management, at about $3,000. At about $3,000 you get your foreman group which represents management. The income and annual wages of people of Massachusetts in 1941 showed 83% at $2,000 a year and 91% at $2,500.

Colorado did not set up their program so that they could sell their over income group on a cash indemnity basis. This is important as you reach your men in the shop through the man in the front office and you must interest them in your program. It is important that you don't tie this hard problem up in your enabling act as some states have done inadvisedly.

5. Types of Contracts. Massachusetts has got what is called a surgical-obstetrical contract. Michigan started out with a complete medical care program and ended up $365,000 in debt. California started with complete care and ended

$100,000 in debt. Utica and Buffalo have given up complete medical care and are back on a surgical program. It appears best to start out on a surgical obstetrical program until we become experienced enough to carry a broader type of coverage. No state program now sells a complete medical care contract as their important contract.

Experience in Massachusetts. When Michigan sold half a million contracts we thought we would do the same easily. We had 3,000 enrolled during the first six months, 23,000 plus, during the first year. Blue Cross sells our contracts. By alliance with the Blue Cross, our overhead expenses can be brought to 12%. No medical program can be sold on any other basis unless you spend 25%. Blue Cross men work on a quota basis. In Massachusetts, the present plan is for each man to sell 200 Blue Shield contracts per month for us and 500 hospital contracts for Blue Cross. We have used the executive director of Blue Cross as the executive director of our medical corporation.

Financial Experience. By the end of the year we will be working in the black. As a sales policy for protection of our financial status, we first required that there be enrollment of 50% of enrolled groups. At a national meeting last winter, I tried to have the plans justify their 50% requirement. It was not done satisfactorily. We have altered our requirements to between 20% to 50% of a group, depending on the length of time they have been covered by Blue Cross and their financial experience with the group. If you go along with Blue Cross you have got to respect their sales difficulties, and help them over the rough spots. We estimate that when we get 10,000 subscribers the estimated income will be $32,000, total operating expenses will be $20,000 and the surplus plus reserves will be $12,000.

Once our corporation is on sound financial footing we plan to extend our coverage to complete hospital-medical-surgical-obstetrical care. Then as experience, demand and costs indicate, we will expand the contract to cover such home and office care as seem capable of proper control and protection against abuse. Experience across the nation seems to indicate that this is the only solid safe approach to this difficult problem in a field where there are no real authorities, as yet.

Discussion:

C. Harold Jameson, M. D., Rockland: I notice in the groups which have undertaken this program that most of the places are sizeable ones. I would like to know if any group with a population like the State of Maine has undertaken this.

Dr. McCann: The States of Colorado, California, Michigan, New Jersey, Massachusetts, have established such programs. Colorado, although somewhat larger, is the State nearest in size to Maine with such a program.

S. Judd Beach, M. D., Portland: I would like to ask whether the program reaches the indigent.

Dr. McCann: As at present constituted it does not reach them, but the social security program won't reach them, either. We must ultimately reach them. Our program is at present restricted to surgical-obstetrical coverage. This must be expanded to meet the needs of both the under income group and the indigent as we acquire experience.

Mr. Paul A. Webb, Executive Director, Associated Hospital Service of Maine: I would like to compliment Dr. McCann on his presentation of the subject. He is not here on behalf of the Blue Cross, but I think that I could not have coached him to present the subject more effectively from the standpoint of our interest in the development of a medical care plan in Maine. Our hospital service plan has been successful, developing its present membership of 71,500 in less than five years of operation, and non-profit medical service plans as developed under the sponsorship of medical societies are near enough like it in fundamentals that I can see no particular reason why a medical plan can't succeed here, too.

While I am on my feet, I would like to read to you just a few sentences from the final report of the Committee on the Costs of Medical Care which was referred to earlier:

"The data in Chapter 1 shows that many persons are obtaining inadequate medical care at rates which for them are excessive, and that many persons who give this care are receiving inadequate compensation. A remedy lies in the organization of producers and consumers. Organization in the field of medical care may come through private initiative or through the initia-

tive of government. That such organization will come seems inevitable. Whether it comes through governmental or non-governmental agencies depends more upon the initiative of the professions and organizations involved than on any other one influence."

That report was adopted 11 years ago this month. Dr. McCann has asked the question whether government will give the medical profession time to develop plans for the adequate distribution of care under payment arrangements that eliminate burdensome costs to individuals. Much time has been lost since the warning given by the Committee on the Costs of Medical Care up to the present furor over the Wagner Bill. You will need to move pretty quickly, now, if you want to take the initiative with a medical care plan, and your next opportunity to get an enabling act will be in 1945.

The Blue Cross represents a piece of machinery now working that can serve your purpose with a minimum of delay if you want to make use of it. I want to tell you just a little about the Blue Cross so that you will not confuse it in your thinking with an ordinary casualty insurance company. We operate under a special charter which, in effect, makes us the agent of our member hospitals. Those hospitals have assumed the responsibility of rendering to our subscribers necessary contract benefits; the hospitals then look to the Blue Cross for payment at the agreed rates. If we lacked funds to meet our obligations in full, the available funds could be distributed to the member hospitals pro-rata in full settlement. Our Maine association has always been able to pay 100% of the basic rate schedule, but because the member hospitals guarantee contract services to subscribers and assume the financial risks of the Association being able to pay, we are relieved of the capital requirements imposed on a casualty insurance company. The control of our association is guaranteed to the member hospitals by the charter provision that a majority of the Board of Directors must at all times be administrators, corporators, trustees or members of the medical staff of our member hospitals.

A revision of our charter passed in the last session of the legislature permits us to operate a medical service plan and, if such a program were undertaken, there should be no great difficulty in giving the medical profession acceptable representation on the board of directors due to the staff connections of physicians with our member hospitals. I think it entirely feasible to determine upon a surgical-obstetrical plan that would merit the sponsorship of the organized medical profession in this state and operate it as an integral part of our hospital service plan. The contracts could be sold and the periodic premiums collected through our present organization; funds paid in for hospital care could be segregated from those paid in for surgical-obstetrical benefits. Disbursements from the medical care fund, except for an agreed percentage to cover administrative expense, could be limited to those certified by a medical referee or committee reviewing all claims. In fact, the administration of the medical plan might well be supervised by an executive committee independent of a like committee now controlling the hospital service plan's business. No difficulties have been suggested here today which can't be worked out within the framework of the Blue Cross if the medical profession in Maine wants to get on with a plan of group budgeting for medical care expense.

I might suggest the approach to the problem that I would like to see made. I would like to see the State Society appoint a committee to work with the Blue Cross in developing a medical care plan which the State Society would approve and sponsor. We could then proceed with the enrollment of participating physicians and the sale of contracts. Perhaps we would need advisory committees of physicians in various areas of the State.

Frederick T. Hill, M. D., Waterville, President—Maine Hospital Association: I enjoyed hearing Dr. McCann. I was at a meeting in Chicago recently at which there was a discussion on the Wagner-Murray-Dingell Bill. While there was considerable criticism of the American Medical Association, when we got through we found we were all pretty much in agreement. This whole program is the work of a group in Washington interested in changing our whole economic status. The Washington incident, terminating in a law suit, furnished valuable ammunition for them. Now we have got to do something or the government will do it for us. I heard Dr. Parron talk recently in Buffalo. He said something that you can't get

around, that "If these groups who are opposing this plan don't have something to offer which is just as good, they had better keep quiet." I feel we must have something more than a defense; a constructive offense. The plan suggested by the American Hospital Association contemplates a further extension of the Blue Cross group to include the lower income groups, and some form of prepayment health insurance, together with grants-in-aid to the states for care of the indigent. In such a plan, I don't see why we shouldn't take advantage of the machinery already available in the Blue Cross. I am sure we can work out any problem with the hospitals. To me it seems as easy to interest the profession in this plan as to set up an entirely new and different plan. I think that it can be done. I think we have the machinery. If we are going to withstand the threats that come out of Washington we have got to work fast. We must utilize what we already have set up for us. I would like to see this done by a committee from the Maine Medical Association in conjunction with the Blue Cross.

Dr. McCann: We are built upon the Blue Cross even using the same common executive director.

Currier C. Weymouth, M. D., Farmington: I would like to ask Dr. McCann how this ties up with the osteopaths.

Dr. McCann: In our State there are only 200 osteopaths who have passed the State Board of Medicine's examination. If we had attempted to exclude the 200 men licensed by the State to practice medicine it is doubtful whether we could have procured passage of the enabling act. We felt, and Michigan has taken the same stand, that licensure by the State on a uniform examination basis, gives a man the right to practice which we cannot abrogate. Some of those men have contracts in our corporation. They have been certified by the authoritative body of the State that they can practice acceptable medicine. I know you face a different problem with two examining boards.

Mr. Webb: We have in the hospital service plan two osteopathic hospitals which are participating member hospitals. I think that their relationship to the Plan has caused no trouble to the other 45 member hospitals. When we enroll an employee group it is important that our offering encourage general participation by the employees not alone for its influence on the number enrolled and the satisfactory averaging of risks, but also because the employer's cooperation is not likely to be enlisted for a plan that discriminates against some of his employees. Take the New England Telephone and Telegraph Company as an example. Periodically, the Company notifies its employees throughout the state of their privilege to participate in the hospital service plan on a payroll deduction basis. Some of those employees employ osteopathic physicians from preference or the unavailability of a medical doctor where they reside. From the employer's standpoint of right personnel relations, isn't it important that these employees also be permitted to budget hospital expense on a prepayment basis and, after having done so, that they be entitled to Plan benefits in an osteopathic hospital if they have an osteopathic physician? No serious difficulties have come out of this.

Dr. Beach: Would you like to tell us a little more about the terms of contract with your surgeons?

Dr. McCann: There is essentially a simple contract set up and a fee schedule for different services. It runs on the very basic values of $25, $50, $75, $100, with a top of $150, and so on. An appendectomy is $75, for three weeks of hospital care. In addition to that we have rules and regulations which are simple. If a doctor signs up as a participating physician he can't withdraw until his intention has been on file for one year. If the people in good faith have bought a thing for one year they should get it. In some states the doctors can get out on three-months' notice. You have got to look at the basic fact that the public buys on the yearly basis and tie your doctors for a year.

In obstetrics we were forced to make a distinction between the special and general man. You can't set up an allowance which would be applicable to both the family physician and the specialist. We set a basic value of $40 for delivery in the hospital. The man who is a full-time specialist in obstetrics is privileged to make an additional charge. There is a ceiling placed on this charge—he can charge an additional $60.

Dr. Jameson: I would like to ask Dr. McCann to tell us on what basis in Massachusetts did the men refuse to come in.

Dr. McCann: About 3,600 or 75% participated. The others include boys in the service or retired practitioners. The reasons some didn't come in were; that they wouldn't accept the fee schedule; they felt that the program was too restricted; there were other men who just won't be "regimented" in any way according to their personal description of the program.

Oscar F. Larson, M. D., Machias, President, Maine Medical Association: I certainly enjoyed Dr. McCann's talk this afternoon on this matter and the comments of Mr. Webb of the Blue Cross. It looks to me as though Washington wants to have a care of everyone from the cradle to the grave. We must do something, if we don't government is going to as has been said many times today. Just what we should do is our problem.

John O. Piper, M. D., Waterville, Council Chairman: It seems to me that from what has been said at the meeting today that we have a problem to face. We have got to do something pretty quick if we are going to do anything about it.

R. V. N. Bliss, M. D., Blue Hill, President-elect, Maine Medical Association: I would like to ask Dr. McCann to elucidate for what reasons doctors in Massachusetts object to tying up with the hospital insurance plan.

Dr. McCann: Rather than basing it on reasons they base it on instincts. If we get too closely organized with them the physicians fear we will lose our professional identity. It isn't a real conflict. However, when you get a council of 270 men together some men who will have had unsatisfactory experiences with hospital groups may throw doubt in the minds of the whole group as to whether it is desirable to be closely identified.

Dr. Larson: There is another question; I think the government in handling their obstetrical cases for the soldiers don't allow the wives of soldiers to enter any maternity home that is not accredited.

Mr. Webb: We have 47 participating hospitals in the State of Maine. In general, we consider any hospital as an accredited general hospital if it has been so registered by the Council on Medical Education and Hospitals of the American Medical Association.

Maternity homes, in general, we do not recognize as accredited hospitals. I believe that a nursing home may be registered as such in the State of Maine if in a period of six months it cares for at least two pregnant women who are not related to the management of the home. Such a standard hardly qualifies the institution as an accredited general hospital. Our Board of Directors may accept for participation in the hospital service plan an institution that is not approved by the American Medical Association and the Board has seen fit to accept as participating members two osteopathic hospitals. Do any of you seriously think that the fact of our having two osteopathic hospitals as member institutions works to the disadvantage of other hospitals in the community? It is important to the success of our plan that we secure large enrollment from employee groups and you work against this when you limit the choice of physician and hospital. The fact that we have two osteopathic hospitals in the hospital service plan has not prejudiced the interests of other hospitals in the plan.

Dr. McCann: I have dealt widely with the Blue Cross men. You are going to be faced with this angle, that their problem is salesmanship and our problem is medical care. I think the Blue Cross people must remember that while they have these problems of salesmanship they cannot ask the profession to give up honest ideals of standards. Indirectly through our hospital staffs we do our best to maintain standards.

Mr. Webb: In this State surgery may be performed by practitioners defined by law. The practice of surgery by osteopaths has been legalized and I do not think that it is for the Blue Cross to say that it doesn't approve of osteopaths. We are not tearing down standards of medical care in taking this position. You may run your medical care standards up as high as you can; you may force the osteopaths to meet a higher standard or suffer legal restrictions or public prejudice. At this time, however, a portion of the population depends on osteopaths for health service and I do not consider it to be the function of the Blue Cross plan to be a rating bureau.

The President's Page

To the Members of the Maine Medical Association:

If you are a reader of history you may wonder if the World of today is taking a swing back to the Dark Ages. Many advanced the idea during the first World War and now during this greater second World War the thought is again rampant in apprehensive minds but is generally received with scorn.

History reminds us that all civilizations of the past have marked the beginning of their downfall by luxurious living, with slowing down of material advancements and finally, with War and Revolution. Are we on that Track?

Theoretically the idea is tenable. Night always succeeds day, winter always follows summer and these variations have their definite uses. Our civilization which has been going at a rapid pace following World War I, although slowed up somewhat in the depression years, is now going full steam ahead. The World and the people in it are like the pendulum of a clock always swinging first to one side and then to the other of perfect stability; and what is more will probably always do so as long as someone furnishes the power and greases the works.

But theories are not for us. In 1944, the New Deal now being officially dead, let us not lose sight of the fact that the paramount issue is to Win the war.

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Editorial

Neuropsychiatry's Importance in Armed Forces Is Emphasized

Journal Says the Recent Incident in Italy Points to Need for Proper Organization of This Branch in Medical Services

"A soldier suffering from what would ordinarily be called a nervous breakdown, a condition classified as a neuropsychiatric disorder, was punished quite unnecessarily by a general. This incident serves to focus attention again on the exceeding importance of proper organization of neuropsychiatry in the medical services so that the most possible can be done to prevent situations of this type in the future," *The Journal of the American Medical Association* for December 4 says. "With the beginning of the Selective Service examinations the importance of preliminary neuropsychiatric study became clear. Just recently the Selective Service Administration has improved its technic for this purpose. Originally it was contemplated that great numbers of neuropsychiatrists would be associated with the examinations of men for military service especially on the induction boards and that sufficient time would be allowed for such study. The speed of recruitment and the lack of sufficient personnel, as well as the failure to develop dependable technics, combined to prevent the type of study that needs to be made if any considerable number of potential cases is to be eliminated from admission to the service. Up to April, 1943, almost half a million men had been rejected for psychiatric reasons. About one-third of all casualties now being returned from overseas are neuropsychiatric. The strain of this war affects leaders, with the added stress of leadership, even more than it does the men in subordinate rank. Already it is clear that constant attendance by qualified neuropsychiatrists may serve to detect potential breakdown among aviators and to restore men in such condition to active service far more quickly than would otherwise be the case. The death of Col. Roy Halloran deprives the division of neuropsychiatry of the Medical Department of the Army of a distinguished leader who was well on the way to the development of adequate personnel and improved services. A successor has not yet been appointed. Since neuropsychiatric breakdown now constitutes a leading cause of disability, resulting in the loss of services of tremendous numbers of men both in the Army and in the Navy, the Secretaries of War and of Navy might well consider whether neuropsychiatry should be a major division in the organization of the administration of the Medical Departments of the Army, the Navy and the Air Forces."

A college president who would never tolerate a contaminated water supply on his campus must learn not to permit an open, broadcasting case of tuberculosis loose among his young people. Sneaking tuberculosis must be painted as the crippler and killer it is, more to be feared than the sporadic, dramatic visits to the campus of such well-publicized maladies as influenza, measles or mumps. Mild illness in the mass fills the headlines, while deadly tuberculosis, working twenty-four hours a day in its own quiet fashion, goes on filling sanatorium beds and cemetery plots.—Charles E. Lyght, M. D.

The trend toward surgical treatment of tuberculosis is perhaps the most significant and far-reaching change which has come about in the tuberculosis hospital field. This has involved changes in design and equipment of the hospital, in the organization by the staff, in provision for nursing of surgical cases, and development of closer relations with general hospitals. Wherever the tuberculosis hospital is not prepared to meet the demand for better operating rooms, laboratories, and rœntgen-ray equipment, the facilities of the general hospital must be utilized.—Editorial, *Penna. Med. Jour.*, March, 1940.

Maternal and Child Welfare

Maternity and Infant Care for Wives and Infants of Service Men

Maternity care for wives of men of certain grades in military service and medical and nursing care for their babies can now be provided without cost to the family through State Health Departments. Under the plan a pregnant woman may receive prenatal care, obstetric care in home or hospital, and final examination six weeks after the baby is born, and the baby may receive medical care during the first year of life. Those eligible are the families of men in the fourth through the seventh grades of the armed services.

The expectant mother makes application to the Director of Maternal and Child Health, State Bureau of Health, Augusta. Blanks can be obtained through local health and welfare agencies, and the Red Cross. Similarly, application can be made for care of the infant during his first year. This should be done as soon as the need can be foreseen, since payment for services will not be given unless authorized in advance (occasional exceptions).

For complete obstetrical care the fee is $35. This includes prenatal care, five or more examinations, delivery, post-partum care, including care of the newborn, and the six weeks' examination. The prenatal care *must* include urine, haemoglobin, and Kahn tests. There is no added fee for operative delivery, but provision is made for payment for expensive items such as oxygen, transfusions, etc. If there is no prenatal care, the fee is $25. The physician must agree to accept no additional fee from the patient. Payment will be made to him on receipt of the completed maternity record. Bills must be rendered in duplicate.

Medical care is offered for the infant in his first year. This is designed to cover monthly examinations where clinics are not available, and the care of real illness. The mother should not expect to be allowed to call the doctor at government expense for trifles. The fees allowable are three dollars for a house call and two dollars for office visits. Adjustments for mileage will be made when necessary. In the event of a prolonged illness the infant should be sent to a ward service where one is available. The mother must obtain advance authorization from Augusta except in emergencies. When an infant is seen monthly for routine examination, it is suggested that the bill be rendered at the end of the observation period to minimize paper work.

Before agreeing to care for a patient, under this plan, the physician should explain to her exactly where she stands. She cannot plan to have luxuries on the strength of having no doctor's bill to pay. She cannot have a private room when ward care is obtainable, nor can she have a private nurse unless authorized for good reason. She cannot call the physician to her home at government expense, nor can she expect later to call him to the baby to explain trifling symptoms. In short, the plan gives her and her baby necessary care, good care, without frills. Unless the doctor explains this carefully, some unreasonable patients will impose on him.

Your committee met and discussed this plan carefully. We admit that the paper work is a headache, but can see no way to keep up standards without it. Soldiers' families are entitled to care, and we feel that it should be physicians' care. These families should become accustomed to high standards of medical practice, both for their own sakes, and for the sake of our absent colleagues when they resume practice. We owe it to these mostly young men to see that growing families are taught to rely on physicians.

The fees are possibly somewhat small. To offset this, we point out that the collections are one hundred percent. This fact will make work under the plan compare well financially with private obstetric and pediatric practice. Accordingly, we recommend that the plan be accepted.

Your Committee on Maternal and Child Welfare.

Necrology

Julius Calvin Oram, M. D., 1885-1943

Dr. Julius Calvin Oram, 58, of 1 Mitchell Road, South Portland, president of the Cumberland County Medical Society, passed away in the Deaconess Hospital in Boston on November 19, 1943. Almost a year before he had had an atypical virus pneumonia which had lighted up a latent asthma that eventually terminated as status asthmaticus.

"Pete" enjoyed life. He was happy in his marriage, family, friends, profession and disposition. The day was brighter and merrier if you chanced to have met him. "Pete" was a friendly man; where most of us have acquaintances he had friends. His ever ready and unfailing source of gentle humor endeared him to all. Despite the busy days of his practice he found time to stop to do many little gracious kindnesses that most of us take credit if we only think of. He had no malice and ever spoke of the good qualities of others. He had no envy and rejoiced in others' success. He was a kindly man and much loved by his community, patients, and brother practitioners.

He was born October 17, 1885, in Bristol, Maine; the son of Captain William and Mrs. L. Elizabeth Oram. He prepared for college at the Westbrook Seminary, then went to Tufts College for pre-medical training from which he transferred to Bowdoin College and graduated in 1911. He worked a year for the American Telephone Co. in Philadelphia and returned to Bowdoin Medical School, graduating in 1915. Following graduation he served an internship at the Central Maine General Hospital in Lewiston. Doctor Oram began to practice near the corner of Franklin and Congress Streets in Portland but soon entered the Army Medical Corps where he obtained the rank of captain. Following the First World War he returned to South Portland to practice. He first had an office on High Street in "Ferry Village" and later moved to Mitchell Road, on the top of Meeting House Hill. He was unusually successful in developing a large general practice but following several periods of study in Boston and New York he had come more and more to limit his work to allergy, in recent years.

He was a member of the staffs of the Maine General Hospital, Maine Eye and Ear Infirmary, and Portland City Dispensary. He found time to take part in the civic affairs of South Portland and served two terms on the school committee and at one time as city physician. He was a member of the Clinical Club, the Portland Medical Club, the Cumberland County Medical Society, the Maine Medical Association, in whose meetings he found great pleasure — and a Fellow of the American Medical Association. He was a member of the Zeta Psi and Alpha Kappa Kappa Fraternities. He belonged to various Masonic orders including Kora Temple, Order of the Mystic Shrine, South Portland Lions Club, Purpoodock Club and the North Congregational Church. He was a director of the South Portland Building and Loan Association.

He is survived by his widow, Mrs. Dorothy Tobie Oram; a daughter, Miss Ruth Isabel Oram; a son, William Vincent Oram; a sister, Miss Alice Maude Oram, a teacher in the South Portland Schools; and his mother, Mrs. L. Elizabeth Oram, all of whom live in South Portland.

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Piscataquis County Medical Society

Kennebec

The annual meeting of the Kennebec County Medical Association was held at the Augusta State Hospital, Augusta, Wednesday, December 8, 1943.

Officers elected for the ensuing year were:

President, Clarence R. McLaughlin, M. D., Gardiner.

Vice-President, Thomas C. McCoy, M. D., Waterville.

Secretary-Treasurer, Clair S. Bauman, M. D., Waterville.

Delegate to the 1944 annual session of the Maine Medical Association, Adolphe J. Gingras, M. D., Augusta.

Councilor for three years, Forrest C. Tyson, M. D., Augusta.

The speaker of the evening was Forrest C. Tyson, M. D., Superintendent of the Augusta State Hospital, whose subject was *Psychosomatic Medicine.*

Knox

The annual meeting of the Knox County Medical Society was held at the Copper Kettle, Rockland, Tuesday, December 14, 1943.

The meeting was called to order by Alvin W. Foss, M. D., of Rockland. The secretary's report was read and accepted.

The election of officers put the same men into office for this next year, with the exception of Saul R. Polisner, M. D., whose place was taken by Paul A. Millington, M. D., of Camden. The officers are:

President, Herman J. Weisman, M. D., Rockland.

Vice-President, Paul A. Millington, M. D., Camden.

Secretary-Treasurer, Abbott J. Fuller, M. D., Pemaquid.

Delegates to the 1944 annual session of the Maine Medical Association: C. Harold Jameson, M. D., Rockland; and James Carswell, Jr., M. D., Camden. Alternates: Drs. Weisman and Fuller.

Censors: Alvin W. Foss, M. D., 1947; Gilmore W. Soule, M. D., 1945; James Carswell, Jr., M. D., 1946.

Neil A. Fogg, M. D., of Rockland, spoke on *Country Surgery,* and told of many unusual operations and experiences of his practice in Maine.

The Knox County Medical Society has had a meeting every month during 1943, and with Doctor Millington acting as president the programs for the coming year should be very interesting as well as valuable.

A. J. Fuller, M. D.,
Secretary.

Pay Your 1944 State and County Dues to Your County Secretary

Notices

State of Maine
Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of Physicians Licensed by the State of Maine, Board of Registration of Medicine, November 10, 1943.

Through Examination

John Everett Cartland, Jr., M. D., Hartford, Connecticut.

John Donadeo, M. D., Pittsburgh, Pennsylvania.

Clarence Everlyn Dore, M. D., Detroit, Michigan.

Harris Bigelow Haskell, M. D., Portland, Maine.

Herman Loeb, M. D., Portland, Maine.

Percy Clarence McIntire, M. D., Brooklyn, New York.

Through Reciprocity

Charles W. McClure, M. D,. West Newton, Massachusetts.

Book Reviews

"Internal Medicine in General Practice"

By: Robert Pratt McCombs, Lieutenant, Medical Corps, United States Naval Reserve; Recently Instructor in Internal Medicine for the Statewide Postgraduate Program of the Tennessee State Medical Association. On leave of absence from the staffs of the Pennsylvania Hospital, the Abington Memorial Hospital and the Jefferson Medical College, Philadelphia.

Published by W. B. Saunders Company, Philadelphia and London, 1943. Price, $7.00. 694 pages.

This volume will serve the general practitioner as a guide to the newer contributions in the field of internal medicine. The first chapter covers adequately the fundamentals of diagnosis and sets forth the latest methods of laboratory technic. There are in all 114 excellent illustrations and 15 valuable tables. The author has, in this concise volume, covered the field of diagnosis and treatment of the more commonly encountered diseases in excellent fashion.

"Medical Malpractice"

By: Louis J. Regan, M. D., LL. B. Member State Bar of California.

Published by The C. V. Mosby Company, St. Louis, 1943. Price, $5.00.

The author of this book is both a physician and a lawyer. It was written for use by the medical profession and the lay public, and attempts to make clear to the medical profession their legal relationship to their patients, with suggestions for lessening the possibilities of malpractice claims. Many illustrative cases which the author observed in the Los Angeles court during 1941-42 are presented together with a comment on the outcome of each case. "The greatest protection available to the individual doctor against a malpractice suit is the taking and preserving of a complete written medical case record."

"This book has been aimed at presenting the subject briefly, yet with sufficient detail to enable the physician to inform himself of his legal obligation to his patient and to learn the ways in which he may safeguard himself against malpractice claims," and is a valuable guide for every physician.

"New and Nonofficial Remedies, 1943"

Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1943. Cloth. Price, postpaid, $1.50. Pp. 772. Chicago: American Medical Association, 1943.

The current volume of New and Nonofficial Remedies continues, with minor improvements, the convenient and informative system of classification adopted for the 1942 volume. The terminology of the official drugs has been devised to conform to the U. S. P. XII and the N. F. VII.

Textual changes and revisions do not appear to be as numerous as in some previous editions. The chapter, Digitalis and Digitalis-like Principles and Preparations, has been extensively and somewhat radically revised to keep pace with the changing attitude toward this drug. It is understood that in this revision the Council had the aid of the foremost digitalis authorities, pharmacologists and clinicians alike. Other revisions have been made obviously to keep the book up to date with medical knowledge.

No such spectacular new additions as the appearance in a previous volume of the sulfanamides is to be noted. Among the more noteworthy of the new additions are Nikethamide, the central nervous system stimulant which was first introduced as Coramine.

No one can examine the successive volumes of New and Nonofficial Remedies without increasing his profound respect for the faithful and unselfish work of the Council on Pharmacy and Chemistry in the cause of rational therapeutics. Each volume represents a progressive milestone on the road of medical science.

A Social Obligation of the Physician—Continued from page 4

Just now Congress shows signs of asserting its rights as an independent legislative body and is endeavoring to better interpret the will of the people which seems to be away from these new fantastic and communistic ideas.

However, too much reliance should not be placed on these trends. Therefore it is the solemn duty of every physician to try to create a favorable public opinion among his patients and friends; to urge their immediate disapproval of this bill; to unite at once behind some prepayment medical insurance plan; and above all, if true to his profession, to become the active directing leader to kill all legislation usurping our free rights in the practice of medicine.

This brief outline of a real impending danger should arouse us to ACTION—ACTION with the thought of our duty to the public to continue and increase the present high standards of medical service. Also it should stimulate our belief and faith in the truth that this kind of medical service can best be obtained in a voluntary way. In the words of Emerson—"Action is a preamble of thought and without it thought alone cannot ripen into truth."

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The Journal
of the
Maine Medical Association

Volume Thirty-five Portland, Maine, February, 1944 No. 2

S 1161*

Edwin W. Gehring, M. D., Portland, Maine

Whenever anything appears on the political horizon that threatens our American way of life, it behooves all Americans to stop, look, and listen. Accordingly, this afternoon, I want to direct your attention to Senate Bill 1161, sponsored by New Deal Senators, Wagner and Murray, to set up government doctoring and hospital bureaucracy that would just about finish off the private doctor by wrecking the best system of medical practice in the world. Not that our present system is perfect, but under it, we have developed the most effective and the most widely distributed medical care that has ever been provided for any comparable number of people anywhere at any time.

As an amendment to the already amended Social Security Act, this bill was introduced on June 3, 1943, and it literally provides for all the ills to which mankind is heir, including a Federal system of medical and hospitalization benefits. It is to this feature of the bill that I respectfully ask you to listen and, unless I mistake not, you will note that, "The voice is Jacob's voice, but the hands are the hands of Esau."

The bill proposes to raise annually by taxation—from payrolls mostly—twelve billion dollars. Of this sum an amount estimated at three billions forty-eight millions is to be allocated to medical care by the government. An exceedingly disturbing feature of this extraordinary measure is the provision to supply so-called *free* medical and hospitalization care for more than one hundred ten million persons. With the humanitarian principle no one can find fault. *But,* says the *Philadelphia Inquirer,* "if this innocent appearing proposal at first glance is designed, as many are beginning to fear, to be the first step toward absolute Federal control of medical practice and hospital service throughout the United States, or even a weakening of private initiative and enterprise in those fields which would be subject to dictation from Washington, then all citizens concerned for their rights have something to think about."

(Nation's Business) Public health authorities are crossing over the line that separates prevention from the treatment of disease. T. V. A. is recruiting physicians for salaried jobs to serve its employees. The Army wants civilian doctors for its munitions factory personnel.

Government subsidized maternity care is available to all wives of service men. Even per-

*Read before the Portland Kiwanis Club on December 14, 1943.

sons injured while collecting scrap metal in the salvage campaign get free medical care.

"Receive a free medical education from the Government while earning fifty dollars a month," is the gist of the Army and Navy program to put five thousand students a year through Medical West Points and Annapolises. So vast is the contemplated permanent military establishment that Dr. Ross McIntire, surgeon general of the Navy, has estimated one-third of the more than fifty thousand war-time medicos will not return to civilian practice.

The war has put so many physicians in uniform (about one to one hundred and fifty healthy soldiers and sailors against one to fifteen hundred civilians, including all the sick and disabled) that many communities are practically doctorless.

This march of federalization culminates *now* in the Wagner-Murray bill (S 1161), for diaper to shroud social security, including *compulsory* nationwide health insurance. This bill would stretch the protecting mantle of social security over every gainfully employed American.

How is the money to finance this colossal project to be obtained? It's very simple. Wage and salary earners will pay a special withholding tax of 3½ per cent — *Nation's Business* states it will be 6 per cent—of their earnings up to three thousand dollars a year, and *employers* will make a like contribution for each employee. Government employees will definitely be taxed only 3½ per cent and equally definitely all *self* employed persons will pay seven per cent. Don't forget the 20 per cent withholding tax—soon to be 30 per cent 'tis said—and 10 per cent for war bonds that already harass the employe. This totals 33½ to 36 per cent of the "take home," to say nothing of state and local taxes and union dues.

Nor would the tax burden end there. The employer's end of the tax would inevitably be added to the cost of his products, thus obliging the worker to pay proportionately more for what he buys. Can't you just hear Miss Blue of the Amos N' Andy cast say "why, that's almost *wonderful*!"

By the way, the big insurance companies, where insurance is *voluntary,* came through the depression about 99 per cent, whereas 3000 cities and counties and one State of the Union defaulted on their Government promises and the United States itself repudiated its solemn promise to pay its creditors in gold.

Does the American workingman want Congress to vote the Government irrepealable power to levy such taxes? This is *compulsory* health insurance which has been tried elsewhere and found wanting.

This nefarious bill, moreover, proposes to take this money from the taxpayer, in part to inaugurate *medical treatment* and *hospitalization* in these United States where the system of medical care that we already possess is the envy of the entire world.

Again, this bill proposes placing in the hands of one man—the Surgeon General of the Public Health Service—not alone 3 billions and 48 millions to *spend,* but the right—with an Advisory Committee which has no authority,

1. To hire doctors—possibly all doctors—at fixed salaries to provide medical service.

2. To designate which doctors can be specialists.

3. To determine the number of individuals for whom any physician may provide service.

4. To determine arbitrarily *what* hospitals or clinics may provide service.

To use a slang expression "that's some power, some authority."

But, of course, one man alone couldn't handle such a task, not even a New Dealer, and so provision is made for 150,000 bureaucrats to assist him, to tell patients where to go and doctors what to do and how to do it.

Having freshly in mind, gentlemen, what totalitarianism has done to Europe, how can seemingly intelligent men like Senators Wagner and Murray allow their names to be associated with a fantastic scheme that would destroy private initiative, reduce medical practice to a routine groove, kill incentive, hinder if not block the entire course of medical research, put the medical profession, if not all professions, in the hands of questionnaire clerks and political job holders, and spell the end *once for all* of everything that we mean when we say the American Way!

The health and hospitalization feature of this bill sounds to *me* as if it had been prepared either by a fanatic or by one of Dr. Kupelian's graduates at Pownal.

If this immature product of an untimely birth is passed, it becomes law on January 1, 1944.

What does this mean for the public? It means 3 billions, more or less, annually of extra payroll taxes and the very worst type of medicine this country has ever known. Why? Because the doctor would be paid by the Government and, presumably, would work eight rather than twenty-four hours a day *and* at a fixed salary. There would be little incentive for him to become skilled in his art, for his advancement would depend upon his influence with politicians rather than on his skill or the character of his work. He would lose initiative because obliged to adopt the methods and prescribe the treatment determined by his superiors. He would have little, if any, personal interest in a patient who was *compelled* to visit him. *His* chief concern, for a time at least, would not be the welfare of his patient, but to make himself politically amenable, to ingratiate himself with the ward committeeman.

Even so, *obliged* to see those assigned to him as often as they desired, they being the taxpayers and he hired to work so many hours a day for a stipulated salary, the demands on his time would so *overwhelm* him that in *sheer desperation* patients would be treated quick and dirty.

Let me illustrate what I mean by citing the case of a genial lodge doctor whom I met early one June morning several years ago as he trudged wearily homeward. I said, "why so glum! What is so rare as a day in June?" He replied, "I am just come from seeing a lodger who *thinks* he is sick." Mind you, he, too, for a fixed sum a year, was expected to respond to as many calls as his lodgers chose to make. "Then," I said, "tell me, did you ever figure up what your calls on these lodge members net you?" "Yes," he said, "ten cents apiece, last year." "And how much was your service worth?" I inquired further. At this, he looked about him to be sure that he might not be overheard and said, sotto voce, "not quite ten cents."

There, in brief, you have the picture of what will happen to *doctors,* once they become regimented, socialized. *It cannot be otherwise.* They are human beings and, as such, they *must* have some stimulus to work. "The laborer is worthy of his hire," it has been truly written. And I say to you, if the government or the people think that they will receive high class medical care from doctors who are mere political stooges, working like slaves for a pittance per patient, and actually numb, stupefied by the excessive demands on their time and strength, *they are due for a rude awakening.*

Human nature will stand about so much. No matter how highly the government doctor may resolve at the outset to render a good service, no matter how large his salary may be, ere many moons, he will shirk his work in spite of himself because of the sheer weight of the load under which he will be obliged to stagger.

What happens to the *patient* under such a system is well illustrated by a skit I heard on the air about three years ago. One of these socialized doctors comes home for supper after a grilling day, sinks into a chair and says to his wife, "Mary, *I'm* dog tired." The wife, knowing there is yet more headache in store for him ere the day is done, says, "Well, eat your supper and you will feel better." Having finished his meal, he proceeds with his slippers to the living-room to relax before the open fire, when she says, "I am awfully sorry, dear, but there are forty-five patients waiting in your office." After indulging in what I should call righteous profanity appropriate to the occasion, he repairs to his office and greets the mob somewhat after this fashion. "All you guys with backache, stand up," whereupon he reaches for the backache slips in a compartment over his desk, hands each one an identical slip, and proceeds similarly with those who have headache, indigestion, constipation, etc., until the office door is *slammed* and *locked* after the last victim.

A perfect combination, you see, of farce and tragedy, for here is a doctor with an expensive education, receiving, let us say, $5,000.00 a year —the amount doesn't matter—on which he pays a 7 per cent tax under this bill, treating by the *wholesale* those with real *and imaginary* ills who have paid from 3½ to 6 per cent of their wages—again the amount does not matter—for downright buffoonery. And again Miss Blue can be heard exclaiming, "Why, that's almost *wonderful!*"

Yes, gentlemen, that is State Medicine. It has been estimated that it would cost 600 millions to *administer* this brilliant set-up, which, please observe, makes no provision for the indigent.

Continued on page 30

*Dietary Inadequacy in Rural Maine**

Homer E. Lawrence, M. D., School Physician, Gould Academy, Bethel, Maine

"So long as I get my beans and 'tater' I'm all right." Such was the reply to a question regarding the customary diet of a patient. Is this indicative of the eating habits of a great segment of Maine population?

It is the purpose of this paper to present the results of a nutritional survey made on a group of rural Maine students, all apparently healthy.

Little study of this problem as it pertains to Maine has appeared in the medical literature. During the past ten years the Maine Agricultural Experiment Station has been studying the nutrition of Maine children.[1] A high incidence of diets low in fruit, eggs, whole grain cereal, and milk has been demonstrated. More recently the nutrition of University of Maine students has been investigated.[2,3] Two separate analyses of the dietary intake of vitamin C by Maine children, and of the associated blood level have been made.[4,5] Both of these reports indicate plasma vitamin C levels of below 0.4 mg per 100 cc. in about 45% of the children in the autumn and 63% in the spring. In addition there was a high incidence of gum inflammation, and an associated low intake of raw fruits and vegetables.

Material and Methods

The subjects of the present study were 154 individuals, whose ages varied from 12 years to 20 years, most of them being between 14 and 18 years of age. Of these, 44 were boys and 110 were girls. One hundred and thirteen of them live at home, eating most of their meals there, and possibly carrying a school lunch. The remaining 41 students live in the school dormitories, where their menus are planned by trained personnel. This group serves in a sense as a control, for it is known that they are offered, whether they eat it or not, a good diet, attractively prepared and served.

Each of these individuals was given a complete physical examination, including urinalysis and a hemoglobin determination by the Haden-Hausser method. In each instance a search was made for the physical signs of deficiency, such as conjunctivitis, keratitis, circumcorneal injection, cheilosis, glossitis, gingivitis, seborrhea of the ears and nasolabial folds, hyperkeratosis, calf tenderness, hyporeflexia, and disturbance of the senses of touch and vibration.

Each individual kept for a period of one week a "diet diary." This consisted of a seven-page mimeographed form; on each page was space for recording the food eaten during one day, under the headings "breakfast," "lunch," "supper," and "between meals." The subjects were instructed to record the *amounts* eaten, in slices, spoonfuls, servings, etc., to record the *kind* of a particular food eaten, and to note complementary foods such as butter, sugar, and cream. In cases in which this was neglected it was assumed the student used butter on his bread, sugar in his coffee, etc., so that any errors are on the side of evaluating the food intake too highly.

About half of the diaries were kept in the late autumn of 1942 when sugar and coffee only were being rationed. The remainder were collected in the early spring of 1943 when food rationing was more general. However, there was no perceptible difference in the percentages of deficiency after general rationing.

Unfortunately it was not possible to make any of the special laboratory examinations which may establish the existence of a subclinical nutritional defect, or biochemical "lesion."

The diaries were evaluated by the method of Donelson and Leichsenring.[6] This is shorter than most methods in common use prior to its introduction, and has been proved statistically accurate. The diets were analyzed for their content of calories, protein, calcium, iron, vitamins A and C, thiamin,

* Miss Phyllis Davis, R. N., assisted in compilation of data.

and riboflavin. The total amounts of these food essentials consumed in the seven-day period were calculated and from this the daily average consumption was derived. These averages were compared with the allowances recommended by the Committee on Foods and Nutrition of the National Research Council.[7]

Table 1

Recommended Daily Allowances[7] for Ages Concerned

	Calories	Protein grams	Calcium grams	Fe. mg.	Vit. A I. U.	Thiamin mg.	Vit. C mg.	Riboflavin mg.
Girls, 13-15 yrs.	2800	80	1.3	15	5000	1.4	80	2.0
16-20 yrs.	2400	75	1.0	15	5000	1.2	80	1.8
Boys, 13-15 yrs.	3200	85	1.4	15	5000	1.6	90	2.4
16-20 yrs.	3800	100	1.4	15	6000	2.0	100	3.0

Table 2

Group Eating at Home — 113 People

Type of Deficiency	Number of Cases and Degree of Deficiency 5-10%	11-20%	21-30%	31-40%	41-50%	50-	Total No. of Cases
Calories	9	24	14	4	5	5	67 (59%)
Protein	5	9	6	7	2	2	30 (26.6%)
Calcium	8	7	16	9	13	33	86 (76%)
Iron	5	11	5	3	1	3	28 (24.8%)
Vitamin A	4	12	7	2	3	0	27 (23.8%)
Thiamin	4	3	2	3	1	1	14 (12.4%)
Vitamin C	6	9	6	8	13	9	49 (43.5%)
Riboflavin	8	11	14	11	7	5	56 (49.5%)

Control Group — 41 People

Type of Deficiency	Number of Cases and Degree of Deficiency 5-10%	11-20%	21-30%	31-40%	41-50%	50-	Total No. of Cases
Calories	4	7	10	3	1	1	26 (63.5%)
Protein	5	6	1	0	0	0	13 (32.0%)
Calcium	3	7	7	0	2	3	22 (54%)
Iron	6	5	3	1	0	1	16 (39%)
Vitamin A	2	0	0	0	0	0	2 (4.9%)
Thiamin	5	0	1	0	0	1	7 (17.0%)
Vitamin C	2	2	1	0	1	0	6 (14.5%)
Riboflavin	3	1	4	0	0	1	9 (22.0%)

Results

The results of the comparison of these records with the recommended food consumption are shown in Table 2.

One's first impression of these figures is that they are very similar for the two groups. There certainly is a sufficient degree of deficiency among the control group to illustrate that *supply* of proper food does not insure

proper dietary *intake;* eating habits are at fault among this group. However, the degree of deficiency among the control group is for the most part less than 30%; in about half the group eating at home it is greater than this. The latter group also shows a much higher degree of vitamin C and riboflavin deficiency.

In Table 3 these total percentages of cases of deficiency for each nutrient are compared with the results of Kelly and Sheppard on a much larger group of private patients.[8]

Table 3

Percentage of Total Subjects Deficient in Each Nutrient

	Group eating at Home	Control	Kelly and Sheppard
Calories	59.0%	63.5%	74.0%
Protein	26.6	32.0	36.0
Calcium	76.0	54.0	46.0
Iron	24.8	39.0	40.0
Vitamin A	23.8	4.9	26.0
Thiamin	12.4	17.0	76.0
Vitamin C	43.5	14.5	13.0
Riboflavin	49.5	22.0	77.0

The control group and the people studied by Kelly and Sheppard are of the same economic class, generally. The figures for the two groups are similar except for vitamin A, thiamin, and riboflavin. The difference in thiamin may possibly stem from the fact that all of the bread and flour sold in local stores is enriched. Consequently our calculations for bread consumption were made on this basis, giving a good thiamin intake where otherwise it might have been poor. The same explanation holds to a much lesser extent for the difference in riboflavin.

Table 4

Incidence of the Number of Essentials Lacking

No. of Essentials Lacking	Percentage of Subjects		
	Group eating at Home	Control	Kelly and Sheppard*
0	8.0%	17.0%	12.0%
1	17.7	14.5	9.0
2	12.5	27.0	17.0
3	17.7	2.5	18.0
4	14.0	12.0	10.0
5	8.0	19.5	9.0
6	8.0	2.5	8.0
7	10.5	2.5	9.0
8	3.5	2.5	8.0

An attempt to correlate the clinical findings with the dietary findings in this group was largely unsuccessful. This is as would be expected in long standing and severe deficiencies, for it has been pointed out that the successive stages in malnutrition are: 1. tissue depletion, 2. biochemical "lesions," 3. functional changes, and finally, 4. anatomic lesions.[9]

It seems entirely possible that the recommended caloric allowance may be too high,

* Percentages estimated from their graph.

for the incidence of undernutrition among these students as measured by height-weight standards does not at all approach 60%-70%. Yet, according to this survey about 60% of our students do not obtain the suggested number of calories.

We have a high incidence of carious teeth, and one wonders whether a diet so deficient in calcium may have some effect on the tooth structure of the individual concerned, or possibly on that of his descendants. Of interest in this regard is the report that Maine lakes, rivers, and springs yield water of relatively low calcium content.[10] Perhaps Maine-grown foods contain even less than the average content of this substance.

In spite of the fact that about one-third of these subjects have diets containing less than the suggested amount of iron, there was no individual whose blood contained less than 13.1 gms. of hemoglobin per 100 cc. This compares favorably with the results in studies of New York City school children, but is far better than reports on children in Pennsylvania and Florida.[9]

Of 28 subjects showing varying degrees of hyperkeratosis, most of them slight, only seven had a dietary deficiency in vitamin A. Likewise there was no correlation between thiamin inadequacy and vibratory or reflex changes. There was no incidence of gum inflammation.

Five subjects were thought to have a magenta glossitis, and four of these had diets from 20% to 50% deficient in riboflavin. The fifth had a diet showing an adequate intake of this substance.

Discussion

It is apparent from this and previous studies that dietary inadequacy is the result of faulty food habits, as well as, and in addition to, economic need. The resolution of the problem is dependent in a large degree on educational measures. Such resolution will probably always lag behind the advance of nutritional knowledge, and the effects of any improvement made may be discernible chiefly in the next generation. The responsibility for the educational measures falls in a like degree on the medical and teaching professions.

What can the practicing physician do in the way of educating the general public toward better habits of eating? The answer to this question lies largely in the dietary "pattern" recommended by the Committee on Food and Nutrition of the National Research Council,[7] and shown below:

Milk, adults 1 pt., children 1½-2 pts.

Egg, 3-4 times a week.

Meat, 1 serving.

Vegetables, 2 servings. One green or yellow.

Fruit, 2 servings. One citrus or tomato and one other.

Potato, one or more servings.

Butter or fortified oleo (100-500 calories).

Whole grain or "enriched" cereal and bread, at least half of the intake.

Sugar, fat, etc., to complete calories.

Obviously the most important of these are the first five — milk, eggs, meat, fruit and vegetables. For practical purposes one may forget the rest, for few are the people who do not get their potato, and bread, now chiefly enriched.

Every patient who consults a physician regarding some complaint the nature of which is not obvious needs a dietary history as much as he needs a review of his other habits, and of systemic symptoms. The most satisfactory way of quickly obtaining this information is to ask the patient specifically about the amount of milk, meat, eggs, fruit and vegetables consumed in a day or week.

Likewise every patient who is given general advice by the physician should be advised regarding his diet as well as regarding his general activity, bowel regulation, and medication. This is of course particularly indicated if the dietary history has suggested possible lacks in certain foods.

Summary and Conclusions

Material from the literature and from personal experience has been presented regarding the incidence of inadequate diets in rural Maine. It would appear that, while the degree of such lack is less than in some other parts of the country, and while it does not ordinarily become severe enough to produce anatomic changes, it is common enough to be important clinically as a possible source of symptoms. The most important deficiencies

would seem to be those of calcium, vitamin C, and riboflavin.

The responsibility of the individual physician in combatting faulty dietary habits is discussed.

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S 1161—Continued from page 25

Please remember, too, that I am not concerned, at least not primarily so, in this discussion with the *cost* of the project. In my opinion, regardless of the amount earmarked for medicine, regardless of the salaries paid the doctors, the people will be paying an exorbitant price for a wretched service.

The fact is, the bureaucrats, ever eager to increase their power with a lavish expenditure of the taxpayers' money, are on the march again, determined this time to make over yet another great segment of the American scheme of things. The August, 1943, number of "Pulling Together," the organ of the National Small Business Men's Association, sums up the situation thus:

"There is no public demand for socialistic practices in the field of medicine, or in any other field in America. There can be no possible excuse for arbitrarily placing men of science engaged in basic human welfare work, under political domination. It would be but a mere step farther, and hardly more inconceivable, to place all religion, all education, all industry, all business activity, all art and culture in the hands of a few willful bureaucrats." End quote.

So I say to you, unless you want a cheap grade of medicine and hospitalization at an excessive price, wire or write your Senators and Congressmen immediately and protest the passage of this bill.

"The best prime minister we ever had, Winston Churchill," has said, quote, "We must beware of trying to build a society in which nobody counts for anything except a politician or an official, a society where enterprise gains no reward and thrift no privilege."

Tuberculosis moves so slowly that we measure its progress against a man's life. Public health men have begun to talk of family epidemics, taking two or three generations to run their course, but a longer perspective may be needed to reveal the play of major cycles.—Geddes Smith in *Plague on Us,* pub. by Commonwealth Fund, 1941.

If the fire departments were to refuse to fight fires started by cigarettes not made in the home county, they would be no more ridiculous than are we when we refuse to fight tuberculosis in a person who has not lived long enough in one spot to establish legal residence.—T. J. Werle, *Health,* May-June, 1941.

Prevention of Vitamin Deficiencies in Wartime ***

Franz R. Stenzel, M. D.,† Waban, Massachusetts

The prevention of vitamin deficiencies is an important problem and, if the duration of the war is prolonged, a serious one. Unquestionably, nutritional deficiencies already exist in the occupied countries, and the United States will have to play a large part in the feeding of those peoples at a later date. We are shipping an ever-increasing amount of food to the United Nations and to our troops abroad.

Our government has instituted a program with which we are all familiar. This includes rationing foodstuffs, increasing production on the farm and in Victory gardens, and preserving food in the home to conserve manpower and material. The Council on Foods and Nutrition of the American Medical Association and the Food and Nutrition Board of the National Research Council function jointly to advise on the rationing of food and the institution of educational programs relative to the food problem.

Vitamin deficiency is but one phase of nutrition. It happens to be the newest one, and the one in which a tremendous amount of work has been done in an incredibly short time. The therapeutic use of vitamins has become routine in all branches of medicine. The altered physiologic states associated with specific vitamin deficiencies are, in general, well recognized and well treated. There are also the milder, less well-recognized, multiple deficiencies that are usually the province of the internist or the general practitioner.

The public mind is readily captivated by the concept of vitamins and their alphabetical nomenclature. Health-giving properties and the vitamin content of processed foods are emphasized. Newspaper and radio advertising has aroused public consciousness. Over-the-counter sales of attractively colored and packaged vitamin preparations have reached tremendous proportions.

Obviously, the answer to the prevention of deficiencies in the face of increasing food shortage in the future is not more and bigger vitamin pills. This is not so facetious as it might sound, and the physician may have contributed at times to the impression that vitamins by definition are found in pills. To prescribe such preparations without having inquired into the patient's diet and without making obvious corrections is but a gesture in the right direction. There is not sufficient material to supplement the diet of the entire population by concentrates and synthetic material, even if it were economically possible to do so. With rationing and such shortages as already exist, many items that are the richest sources of vitamins are unobtainable in sufficient amounts to be included in the daily diet. It becomes necessary to look a little farther down the list, so to speak, and include larger amounts of less rich but more available foods.

This is well illustrated by ascorbic acid. People have largely depended on a daily intake of orange, pineapple or tomato juice—now obtainable only in limited quantity. The logical answer is the increased consumption of cabbage as salad or of potatoes properly cooked. All fruits, berries and vegetables contain significant amounts of ascorbic acid. In England a Walt Disney-like character called "Johnny Potato" is used in cartoons and posters to popularize the increased consumption of potatoes. Approved methods of cooking are published and prizes offered for novel ways of preparing potatoes without destroying their ascorbic acid content.

Many publications contain tables giving the vitamin values of particular food sources. These are usually unreliable and misleading. They are often based on the fresh, uncooked animal or vegetable source. The ascorbic acid content of green vegetables and fruits, for example, increases steadily to a maximum just before the fruit is ripe and then decreases steadily. The amount in a given fruit or vegetable is also influenced by proper fertilization and methods of growing. With many fruits an added factor is whether they are tree ripened or picked while green and allowed to ripen in storage. Further,

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* Presented at the annual meeting of the Massachusetts Medical Society, Boston, May 26, 1943.

** Reprinted from *The New England Journal of Medicine,* Vol. 229, No. 23, Page 859.

† Visiting physician, Newton Hospital.

the amount of vitamins contained in food after cooking or preservation varies as the process involves cooking, heating, washing, bleaching or the addition of chemicals. It can be readily appreciated that this multiplicity of factors makes for a wide difference in specimens of food as they are found on the table.

There has been set up a table of figures by the Council on Foods and Nutrition of the American Medical Association giving what constitutes daily vitamin requirements in the light of present-day knowledge. These are admittedly an approximation and at best a rough estimate. Changes must be made relative to age, pregnancy, lactation, infection and specific diseases. Revision of these figures tends to be upward as knowledge concerning the requirements is accumulated. It is well to have some basic table in mind as a point of departure. Special requirements with reference to altered physiologic states and specific diseases will not be discussed, as the present rationing system permits additional food in such cases at the request of the physician.

All known vitamins with the exception of vitamin D are synthesized by plants and used by them essentially for the same purpose as by man and animals. Man, however, is unable to synthesize these compounds, with the exception of vitamin D, and must depend on ingestion for his supply of vitamins or their precursors. Vitamins do not furnish energy and are not building units for the structure of the body, but are necessary for the transformation of energy and the regulation of metabolism. There are many gaps in the details of the physiological chemistry of these substances, but evidence has accumulated so far as the better-known vitamins are concerned regarding the general role that they play in the body. There is also a long list of lesser-known substances that apparently contain vitamins. The knowledge of these is fragmentary, their role in the human body is unknown, and no estimate concerning their requirements can be formed. These will not be discussed, but a review of the better-known vitamins should serve to indicate under present conditions the principal available sources, the changes in diet and certain points of preparation of food in order to prevent avitaminosis.

There is not much danger of avitaminosis so far as the A group of vitamins is concerned, provided that there is an adequate intake of vegetables. The daily requirement for the average person is 5000 international units. This is not increased during body activity, but is greater in lactation and pregnancy. Excluding restricted and scarce items, such as dairy products, eggs and liver, the principal sources are green-leafy and yellow vegetables. A single serving—that is, 3½ to 4 ounces of beet tops, kale, mustard greens, spinach or turnip greens —will supply well over twice the daily requirement. A serving of carrots will supply about the same amount. The same serving of summer squash will provide a little over the daily requirement, and sweet potatoes a little under it.

As another approach to prevention of vitamin deficiency in the A group, the Council on Foods and Nutrition has recommended the fortification of oleomargarine to a level of 9000 international units per pound, so that 1 ounce will provide one-fifth the daily allowance. The fortification and wider sale of oleomargarine is barred by law in some states and is opposed by dairymen, but there is no question that it provides a suitable vehicle for vitamin A. There is little difference between butter and oleomargarine except for a lower percentage of unsaturated fatty acids in the latter.

In considering the prevention of deficiencies in the vitamin B group, it should be pointed out that the deficiency of a single factor is an exception rather than the rule. These vitamins resemble enzymes and are concerned with the utilization of specific food substances. For example, the riboflavin enzyme system is concerned with the utilization of the essential amino acids, and a deficiency of such amino acids would eventually produce the clinical picture of riboflavin deficiency.

The known members of this group consist of thiamine, riboflavin and niacin. The other members have not been identified or have been studied so inadequately that their function and requirements are unknown.

Thiamine is said to be required in a daily dose of 1.8 mg. for the average person. This requirement is increased with activity, and also during pregnancy and lactation. The outstanding source of thiamine is lean pork. One 4-ounce serving provides almost the daily requirement. The next richest source is dried brewer's yeast, an ounce of which is equal to about the

same amount. Thiamine is usually obtained in small quantities from a great many foods, including meat and vegetables. The most available sources are whole-wheat bread and whole-grain cereals. Dried peas and beans are also important. The problem of thiamine deficiency is obviously more acute now, with the rationing of meat and a probable decrease in the supply of pork as the war continues. Furthermore, the available amount of brewer's yeast, which is the principal source of natural thiamine concentrates used therapeutically, is inadequate.

This problem was a real one in England and was solved satisfactorily by the increased consumption of peas, beans and other sprouts. The bread in current use for the last several years in England has been made from an 85 per cent extraction flour. Sydenstricker,* who recently described his experience in examining several thousand persons in all parts of the British Isles, stated that the incidence of vitamin B group deficiencies is extremely low. He added that many people were homeless and so closely touched by the war that their incentive to consume these rather unpalatable foods as a constant diet is greater than before.

It is of interest in this connection that one of the largest baking companies in the United States bought the Earle flotation process — a method of getting rid of the woody portion of the hull, which lends a bitter taste to cereal products. This company developed the process, adapted mills to its use, and attempted to market an almost 100 per cent whole-grain bread that was priced the same as the usual white loaf. In spite of a vigorous advertising campaign, the bread did not sell, although it was recommended by nutrition authorities. The experiment was given up except in a few communities that are used as a barometer for public buying tastes.

From a scientific standpoint it would seem that to extract and bleach flour, reducing the vitamin content to about 10 per cent of the whole grain and then fortify it with vitamin concentrates, is a wasteful procedure. On the other hand, if the public will not eat whole-grain bread, this may be the only way that a deficiency can be prevented. Bread also provides a useful vehicle for the addition of riboflavin to the diet.

The next most important factor in the vitamin B group is riboflavin. The requirement is approximately 2.7 mg. per day, or almost twice that of thiamine. The requirement is increased with activity, is in proportion to body weight, and is higher in lactation and pregnancy. Milk is the most important source; one pint supplies half the daily allowance. Meat is another important source, the usual serving supplying about one-twelfth the daily allowance. The richest source is liver—4 ounces yields over 3 mg. Riboflavin is readily destroyed by light; it is soluble in water and therefore there are losses in cooking. Omitting liver and brewer's yeast, which cannot be advocated for general use because of their limited supply, one comes again to the dried sprouts and vegetables such as peas, beans, spinach, cauliflower and peanuts. An increased consumption of these items, together with a pint of milk daily and the use of enriched bread, is the principal method of combating riboflavin deficiency. It should be emphasized that evaporated, powdered or skim milk can be substituted for fresh milk. It is important too that milk that stands in clear glass bottles in sunlight soon loses its riboflavin content.

Niacin, formerly called nicotinic acid, is the third important member of the vitamin B group. The daily allowance is ten times that of thiamine, or 18 mg. The outstanding source is liver, a 4-ounce portion containing somewhat more than the daily requirement. A serving of red meat will furnish from 7 to 10 mg. in each 4 ounces. Dried brewer's yeast in the amount of 1 ounce yields well over half the daily requirement. This vitamin is relatively stable to heat and there is little loss through cooking, although it is soluble in water. Here again, bran and whole-grain cereals are the most important available sources, although peanuts, potatoes and carrots must be included.

The members of the vitamin B group are often discussed together. Their high value in liver, brewer's yeast and meat, all of which are limited in supply, added to the fact that their best secondary source is whole-grain cereals and legumes, indicates a number of points in common. As already stated, there is reason to believe that the general public does not react

* Sydenstricker, V. P. An address given at the Medical College of Virginia, March, 1943.

favorably to dark whole-grain breads and cereals. Bakers are now launched on a program of enriching bread with these three factors. This may be the answer to the problem, although as the war continues it may prove necessary to return to peas, beans, dark bread and potatoes in far greater quantities than anyone would enjoy. The physician in his daily contact can do a great deal to encourage the use of these items. In order to increase the consumption of such carbohydrates fat is necessary: first, because carbohydrate is eaten more easily if it is greased with butter, margarine or drippings; and second, because fat acts as a thiamine sparer in the body.

It is of interest that tests have been conducted on bread to show the loss of vitamin in baking. The bottom crust may show a loss up to 34 per cent of the total thiamine, whereas the top crust may show a loss up to 13 per cent. Toasting a slice of bread destroys somewhere between 11 and 25 per cent of the total thiamine content, depending on the time of toasting and the thickness of the slice.

A consideration of vitamin C shows little reason why there should be any extensive deficiency. Although transportation and preserving facilities limit the supply of the favorite sources, such as oranges, tomatoes and pineapple juice, an adequate intake of a variety of home-grown and preserved berries, fruits and vegetables will ensure sufficient vitamin C. Raw cabbage and potatoes are good sources. The average adult requires about 75 mg. The vitamin may be lost in cooking, both because it is soluble in water and because it is destroyed by oxidation.

Previous reference was made to the method of preparing potatoes. A 5-ounce serving of boiled or baked potato provides 25 mg. or about one-third the daily requirement. When potatoes are fried, the ascorbic acid is cut in half. Mashed potatoes show a severe reduction in the vitamin C content, and whipped potatoes lose the entire amount.

Vitamin C has been shown to be present in sweat, as is thiamine. It is known that riboflavin is needed in proportion to body activity. It has been suggested that in addition to feeding salt tablets to defense workers in heavy industry or under conditions of increased heat, thiamine, riboflavin and ascorbic acid be added either in the form of concentrates or as further allowance of food.

The average adult has little possibility of developing a vitamin D deficiency except in conditions of unusually scant exposure to sunlight. This vitamin is synthesized by the body and there is excellent storage. In the winter months an adequate intake should be assured through the diet or by the routine ingestion of concentrates. The outstanding source is fish-liver oil. Some varieties contain as much as 40,000 international units per gram of extracted material. Others contain little or no vitamin D. Eggs are an excellent source, and liver is of definite value. The acuteness of the problem varies with the available supply of these items.

It has been demonstrated that irradiation gives cereals, meat, milk, eggs and various oils anti-rachitic properties. At the present time milk is the most suitable medium for irradiation and is available in most urban communities.

A point that is insufficiently emphasized with reference to the fat-soluble vitamins A and D is the ingestion of mineral oil. This substance is inert and is not absorbed. It has been conclusively shown that absorption of the fat-soluble vitamins does not take place to any extent from a mineral oil solution. There are many patients who use large amounts of mineral oil over long periods of time. The use of mineral oil salad dressing in reduction diets means the constant ingestion of mineral oil with the food and is of questionable advisability. If used, mineral oil is best taken at bedtime after digestion of the evening meal is completed, when it interferes as little as possible with the absorption of vitamins A and D.

Conclusions

Deficiency in the A group of vitamins can be avoided by the daily intake of green-leafy and yellow vegetables, and by the use of fortified oleomargarine when dairy products are unavailable in adequate amount.

Deficiency in the vitamin B group is best controlled by the use of fortified bread, and the physician should encourage the use of whole-grain bread and cereals. The constant use of toasted bread should be discouraged. The average adult should drink a pint of milk a day or

Continued on page 40

The President's Page

After the War! What?

At the conclusion of this World conflict the physicians of this Country want more than anything else to get back to individual initiative and enterprise.

Initiative and Enterprise that has given the United States the best general health of any Country in the World; it is a well known fact that we are less afflicted with preventable diseases, are more secure in the survival of our offspring to maturity, and have an average expectancy of life greater than that of any similar population group in the history of man.

For a great many years socialized medicine has been on trial in a number of European countries, yet today the United States, as I have before stated, is the healthiest Country in the World; we are today at the very zenith of a march of progress towards National Health.

It is up to us, as well as other professional groups to decide whether this Country shall continue as a democracy or whether we are to submit to bureaucratic government control, in the form of socialism, communism or what have you.

Hon. A. L. Millar of Nebraska, in a speech before the House of Representatives says in part, "The practice of medicine under the free institutions of this country of ours has advanced the healing art until it is the envy of the whole world. In the short space of 150 years it has so improved the health of this nation that the life expectancy has nearly doubled."

Let us remember that our great medical schools, colleges, and research laboratories were founded by free men.

Let us carry on—

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Describes Method Which May Combat the Shock from Burns

Preliminary Report on Sodium Lactate by Mouth Instead of Plasma Transfusion Is Made by New York Physician

A possible means of combating the frequently fatal shock that accompanies severe, extensive, third degree burns is described in *The Journal of the American Medical Association* for January 22 by Charles L. Fox, Jr., M. D., New York, in a preliminary report on the administration by mouth of sodium lactate solution instead of administering plasma by injection into a vein. (Sodium lactate is an organic salt found in sour milk, certain other substances and in the arterial blood plasma.)

"The results were so successful as to warrant further extensive trial of this therapy," he says. "There was but one death (which occurred within four hours after admission) in 17 cases of full thickness [third degree] burns."

As Dr. Fox points out, "The shock syndrome which follows severe burns is accompanied by hemoconcentration [concentration of the blood corpuscles] and diminished plasma volume." Recently plasma transfusions have been used as a means of restoring the diminished plasma volume.

"Recent accounts of two catastrophes involving many burn cases, the Japanese attack at Pearl Harbor and the Cocoanut Grove fire in Boston," Dr. Fox says, "have indicated the relatively high mortality from severe burns even when large amounts of plasma are used. The English experience with serum or plasma also revealed a high mortality from burn shock."

He points out that recent investigations have revealed that when large plasma transfusions were administered soon after the receipt of the burn, there was not as great a rise in the plasma volume as had been anticipated, and, as a rule, the rise that was obtained proved to be only temporary. As far back as 1926, Dr. Fox says, the late Dr. E. C. Davidson advised the administration of sodium chloride (common table salt) in severe burns instead of dextrose solutions, because Davidson had observed that the plasma chlorides of patients suffering skin burns were low and the urine almost devoid of sodium chloride for as long as three weeks after the burn, in spite of adequate salt intake.

The procedure reported by Dr. Fox involved the immediate administration by mouth of large amounts of a chilled sodium lactate solution and at fifteen minute intervals thereafter on schedule. Any vomiting, which frequently occurs in severe burns, was treated by the administration of more fluid, and frequently a small tube was passed through the nose and connected with a drip apparatus so that the sodium lactate was administered constantly. A very careful record of fluid intake is necessary and the urinary output has to be carefully watched and all urine collected.

All cases of heat burns admitted to Harlem Hospital since Feb. 1, 1943, and 1 case of severe burns admitted to the Babies Hospital have been treated according to this procedure. The local treatment of the burns involved the application of an ointment containing tannic acid and either sulfadiazine or sulfathiazole.

"In general," Dr. Fox says, "the large volumes of fluid were well tolerated; the patients wanted water to drink but after a short time became accustomed to the lactate and drank copiously of their own volition. Occasionally, frequent vomiting occurred and was treated by passing a Levine tube and administering the lactate by steady drip. When the initial vomiting persisted, intravenous infusion was used temporarily to support the circulation until the stomach became adjusted to receiving the steady flow of sodium lactate. . . .

"As these cases required from one to eight skin grafting operations, the extent of full thickness burn could be definitely ascertained. The results in these severe burns constitute prima facie evidence of the therapeutic efficacy of large amounts of oral sodium lactate instead of intravenous plasma. . . ."

Dr. Fox says that the observations by Davidson on the disappearance of the chlorides from the urine were strikingly confirmed in the series of cases he reports. Further studies of the re-

distribution of sodium by the body are in progress, and an extension of the studies he and his colleagues have already inaugurated may answer, he says, the important question as to whether a judicious combination of small amounts of plasma with sodium lactate might be more effective than sodium lactate alone.

"Whatever may be the ultimate conclusion about the added benefit of small amounts of plasma," Dr. Fox continues, "the fact that extensively and severely burned patients survived and recovered after the oral administration of isotonic sodium lactate instead of the intravenous injection of plasma, proves that correction of the sodium imbalance is of major importance. . . .

"The simplification in the care of such patients is worth noting. Intravenous therapy is dispensed with and the medical staff and nurses are relieved of this burden. The sodium lactate costs but a few cents and the hospital supplies of blood and plasma are conserved. The problems of sterile solutions are eliminated.

"It is scarcely necessary to mention the military advantages of the simplification of shock therapy that would follow conclusive demonstration of the efficacy of this treatment of burn shock. For the present at least, the emergency use of this method under circumstances in which plasma is not immediately available seems clearly indicated. . . ."

He admonishes, however, that final judgment on this method should await more complete reports.

Necrologies

Horace J. Binford, M. D., 1856-1944

Horace J. Binford, M. D., 87, veteran physician, died at his home in Mexico, Maine, Sunday, January 16th, 1944.

He was born at Chatham, New Hampshire, December 27, 1856, the son of Cyrus and Olive Sawyer Binford. He attended Fryeburg and Bridgton Academies, studied medicine under Dr. Lowell Lamson of Fryeburg, and was graduated from Dartmouth College. He received his medical degree from the University of Vermont Medical School in 1885. Doctor Binford practiced at North Sandwich, New Hampshire, before locating in Mexico in 1893, a practice which he continued until his retirement a few years ago because of ill health.

He was a member of the Oxford County Medical Society, the Maine Medical Association and the American Medical Association. He was presented with the Maine Medical Association's gold medal in recognition of fifty years in the practice of medicine at the June 1935 annual meeting of the Association

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Ivan Staples, M. D., 1883-1943

Ivan Staples, M. D., 60, widely known Oxford County physician and former examiner for the United States Pension Board, died at his home in Norway, Maine, Friday, December 3, 1943.

He was born at Limerick, Maine, December 29, 1883, the son of Freeman and Luella Pike Staples. He was graduated from Limerick Academy, and received his medical degree from Bowdoin Medical School in 1909. Doctor Staples practiced in West Paris, and West Sumner before locating in Norway twenty-four years ago.

He was a member of the Oxford County Medical Society, the Maine Medical Association, and the American Medical Association, and of the Masonic bodies.

He is survived by his widow, a brother and two sisters.

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County News and Notes

100% Paid Membership for 1944

Piscataquis County Medical Society

Androscoggin

The annual meeting of the Androscoggin County Medical Association was held January 20, 1944, at St. Mary's General Hospital, Lewiston, Maine.

Officers for the coming year were elected as follows: (All officers were re-elected with the exception of the last two alternates)

President, D. F. D. Russell, M. D., Leeds.
Vice-President, R. A. Beliveau, M. D., Lewiston.
Secretary-Treasurer, L. C. Gross, M. D., Auburn.
Councilors: W. J. Fahey, M. D.; B. W. Russell, M. D.; C. H. Rand, M. D.

Delegates to the Annual Session of the Maine Medical Association: R. A. Goodwin, M. D., Auburn; H. L. Gauvreau, M. D., Lewiston; W. H. Chaffers, M. D., Lewiston.

Alternates: A. W. Plummer, M. D., Lisbon Falls; B. W. Russell, M. D., Leeds; P. R. Chevalier, M. D., Lewiston.

Paul R. Chevalier, M. D., former Captain, M. C., U. S. Army, who was a member of the Maine unit, was speaker of the evening. Doctor Chevalier told of his experiences in England while he was stationed there with the 67th General Hospital.

LEROY C. GROSS, M. D.,
Secretary.

Kennebec

The Annual meeting of the Kennebec County Medical Society was held at the State Hospital, Augusta, Maine, on December 8th, 1943.

The members of the society were guests of Dr. Forrest C. Tyson, for dinner which was served at the Augusta State Hospital. After dinner the meeting was called to order by Dr. A. J. Gingras, President. The minutes of the previous meeting were read and approved.

The President received the report of the auditors of the books which were declared to be satisfactory. The treasurer's report revealed the finances of the society to be in sound condition.

Drs. B. O. Goodrich, W. J. O'Connor, and Chalmers Farrell were appointed as a nominating committee. Officers for the ensuing year were published in the January issue of the JOURNAL.

The Secretary of the State Medical Association, Dr. Frederick R. Carter, was present at the meeting. He was re-introduced to the society and spoke briefly on the Wagner-Murray Bill.

Dr. Forrest Tyson, speaker of the evening, gave an interesting talk on *Psycho somatic medicine.* This was followed by numerous questions in the general discussion.

Dr. McLaughlin, our new president, was called upon and responded with appropriate remarks.

Dr. Tyson was given a rising vote of thanks for his hospitality to the Society.

There were 23 members present at the meeting.

CLAIR S. BAUMAN, M. D.,
Secretary.

Knox

A meeting of the Knox County Medical Society was held on January 18, 1944, at the Copper Kettle, Rockland, Maine. Doctor H. J. Weisman, President, presided.

The minutes of the previous meeting were read and accepted.

Doctor George Young, of Skowhegan, was the guest speaker, and spoke on the general subject of *Pneumonias.* His talk was so clear cut and informative that the border-line distinctions between the various types seem to be enough to enable us to properly diagnose and treat our pneumonia cases this winter. Doctor Young's enthusiasm and wide experience and knowledge of lung conditions make him one of the most vital speakers we have ever met.

A. J. Fuller, M. D.,
Secretary.

York

The Annual Meeting of the York County Medical Society was held January 15, 1944, at the Webber Hospital, Biddeford, Maine. Dinner was served at the Winnie Hebert Restaurant on Main Street at 1:00 P. M., followed by the business meeting at 2:00 o'clock.

The report of the Nominating Committee, Drs. MacDonald, Dolloff, and Prescott, was accepted, and the following Officers elected for 1944:

President, Waldron L. Morse, M. D., Springvale.

Vice-President, Harry L. Prescott, M. D., Kennebunk.

Secretary - Treasurer, C. W. Kinghorn, M. D., Kittery.

Board of Censors: David E. Dolloff, M. D., Biddeford, 1944; James H. MacDonald, M. D., Kennebunk, 1945; Owen B. Head, M. D., Sanford, 1946.

Delegates to Annual Session of the Maine Medical Association: Edward M. Cook, M. D., York Harbor; James H. MacDonald, M. D., Kennebunk; C. W. Kinghorn, M. D., Kittery.

Alternates to Annual Session: William H. Kelly, M. D., Sanford; Oscar Perrault, M. D., Biddeford.

Committee on Resolutions: David E. Dolloff, M. D., Biddeford; Gerald R. Smith, M. D., Ogunquit; Edward M. Cook, M. D., York Harbor.

The annual report of the Secretary-Treasurer was read and accepted. It was voted to have the next meeting at the Henrietta Goodall Hospital at Sanford. Dr. Waldron L. Morse to make arrangements.

The discussion on dues was voted to be left to the next meeting.

Frederick R. Carter, M. D., Secretary-Treasurer of the Maine Medical Association, gave a short talk.

Commander H. T. Pargeon of Portsmouth Naval Prison was guest speaker, his subject being *Rehabilitation of Naval Prisoners,* followed by a Round Table discussion.

C. W. Kinghorn, M. D.,
Secretary.

Pay Your 1944 State and County Dues to Your County Secretary

Prevention of Vitamin Deficiencies in Wartime—Continued from page 34

its equivalent in the form of evaporated or dried milk used in food.

Ascorbic acid deficiency can be prevented by the increased use of a varied diet containing fruits, berries and vegetables.

Deficiency in the vitamin D group can best be prevented by adequate exposure to sunlight and the ingestion of eggs and liver when available. If these foods are unavailable, irradiation of food may become more widespread. The routine use of fish-oil concentrates may be advisable under special conditions.

The physician should assume greater responsibility in advising patients with regard to diet. The war may serve the purpose of improving food habits and introduce improved methods of cooking and preserving food.

1801 Beacon Street.

The Journal
of the
Maine Medical Association

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*Occupational Diseases of the Skin in Maine**

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Introduction

On account of the war, the State of Maine which had had up until now an agricultural and lumber activity, changed suddenly to an intensive industrial activity. This change in economic life has caused modifications in the pathologic condition of workers. We see more and more cases of occupational skin diseases which create each time a new problem for us. It was in order to familiarize ourselves with these problems that I suggested to the Portland Medical Club a general discussion of these affections which we call occupational dermatosis when they are chronic and occupational dermatitis when they are acute.

It is not my intention to treat the subject in its entirety. It is much too vast and complex. There is no occupation which is exempt from that of the office worker where carbon paper may cause a rash, to that of the shipyard worker. I am limiting my subject to general considerations concerning diagnosis, prevention and treatment. Then I will discuss certain cases especially those we run across in Maine. I will not mention the skin diseases caused by explosives and war gases. They are important today, but fortunately are not seen in this part of the country.

Incidence

However, before treating the question of occupational dermatosis in Maine, let me give you a general idea of these affections. They represent today 15% of all skin diseases, and 65% or more of industrial diseases. You can realize the losses suffered by industry in knowing that each case of occupational dermatitis represents an average loss of time of 10 weeks. The most frequent causes of dermatitis are: petroleum products; solvents other than mineral oil; alkalis and compounds; chromates and chromic acid; metals and plating; dyes; paints, varnishes and enamels; rubber and its compounds; synthetic resins; acids and fumes.[1]

I would like to give you the figures of incidences of occupational dermatitis in Maine, but as these diseases are not compensated in this State, there are no official statistics.

Definition

In 1939 the Council of Industrial Health adopted the following definition:

* Read before the Portland Medical Club, November, 1943.

"An occupational dermatosis is a pathological condition of the skin for which occupational exposure can be shown to be a major cause or contributory factor."[2] To express it more simply, it is in the majority of cases a poison rash, a contact dermatitis, the irritant being of occupational origin.

The same Council then tried to give a definition of what is meant by irritant. They recognize two types: primary irritants and sensitizing agents.

(a) The primary irritants are substances which irritate everybody's skin, not previously sensitized to them. These substances are such as acids, alkalines, metallic salts, soaps, cleansers, etc.

(b) By contrast, a sensitizing agent is an irritant which produces reactions only on the skin of persons who are hypersensitive to it. The Council carefully avoided in its definitions the word "allergy" which often provokes arguments. I am not entirely satisfied with this classification. To call acids and alkalis "primary irritants" seems to me inaccurate. These substances cause burns and a burn is not an occupational dermatitis, but an injury even when it is a first degree burn with simple redness. On the other hand the sensitizing agents are supposed to irritate predisposed persons only. But we know, since Bruno Bloch's research that anyone can become hypersensitive to these sensitizing irritants. The only difference between people is the length of incubation and the doses before the appearance of first symptoms. Some patients react immediately after the first contact, others after weeks or even months.[3]

We have here a first and very important denial of this theory according to which predisposed persons only are affected. One other even more important denial may be added: for some authors contact dermatitis (and occupational dermatitis is a contact dermatitis) is not the result of a general allergy, nor even of a local allergy, but the result of minute and repeated injuries to the skin. Some skins have a greater capacity to be injured than others. If this last theory is true, there is no difference between occupational dermatitis and labor injury of the skin, and both should be compensated on the same scale.

Legislation

The uncertainties of the medical theories were bound to be reflected in the legislation concerning these diseases. I am only going to discuss the medical aspects of the legislation. I will pass over the purely legal aspects of the question which are not in my line.

In Maine, labor injuries are compensated whereas occupational dermatitis are not. And that is logical if it is true that they are the result of a special constitution of the patient. In other states, such as New York and Massachusetts, occupational dermatitis are compensated on the same basis as labor injuries.* I have no intention of taking sides in this discussion. All I can say is that in Maine as in other states which oppose occupational dermatitis and labor injuries the examiner role is difficult. Here are a few personal examples:

(a) A worker tars a road. Some drops of tar burn his skin. Everyone is agreed that that is a labor injury and he is compensated. Another worker with the same occupation develops little by little a coal tar folliculitis on his forearm, that is an occupational dermatitis and is not compensated. Another worker with the same occupation has been burned in several places with coal tar. All around his burns appear little by little a persistent tar folliculitis. At that time it is admitted that the poison from the tar has entered the skin through the burns. The occupational dermatitis is a complication of a labor injury and is then compensated.

Another example: In a Portland baking company 3 pastry makers developed on their palms a "cinnamon dermatitis." That is an occupational dermatitis and is not compensated. A fourth pastry maker developed the same rash; but the rash started, the patient says, a few days after minute erosions on palms, ero-

* Speaking of which, I think it is interesting to note the methods employed in Germany which was the 1st country to compensate occupational dermatitis as labor injury. This measure sounds very favorable to the worker, but actually it works a hardship on him. For instance, if a worker is found to be allergic to dyes, he is compensated, but automatically excluded from a whole series of jobs such as dyer, furrier, hatter, shoe maker, hairdresser, chemist, druggist, photographer, maker of artificial flowers, etc., etc., and even rubber maker when the rubber is reduced by using aniline. In all these occupations he could be in contact with products chemically related with aniline.

sions caused by his mixing bowl. This time the erosions are a labor injury and the pastry dermatitis is a complication of the labor injury and is compensated.

All that is specious, brings about quibbles between lawyers, which are not based on solid scientific grounds. At least the controversies show up the importance of an accurate diagnosis, and that is often difficult.

History of the Disease

The diagnosis of an occupational dermatitis is established through 3 elements: the history of the disease, its characteristics, the patch tests. Of these elements, the history is the most important.

(a) It shows that occupational dermatitis was not present before the patient entered on the occupation.

(b) It shows that occupational dermatitis developed during the period of industrial exposure.

(c) It shows that dermatitis developed when the worker is at work and improves when he is away from work and recurs when he goes back to work. Some cases are typical, getting worse every day with a temporary improvement over the weekend and relapsing each Monday on resuming work.

(d) In addition, the history shows that there have been no exposures outside occupation which could be implicated and that other workers similarly employed are similarly affected.

I have just quoted nearly word for word a recent article of the *J. A. M. A.*[2] If one of these factors is missing the occupational nature of the dermatitis is doubtful. Here is a personal experience. A carpenter is referred to me for a rash which appears while working. Patch tests with sawdust and glue are negative and diagnosis remains uncertain. When the rash is over, the patient resumes work, but immediately develops the same rash, worse than ever. I begin all over again, and find that I forgot to investigate several points, including question of working clothes. The worker confesses that while working he wears a khaki flannel shirt, the same kind he has worn for years. But a patch test made with this shirt is strongly positive and the whole trouble was due to this shirt.

To sum up, the case history is the most important part and the 1st examination takes frequently an hour.

Characteristics of the Lesion

The lesions characteristics are essentially their site. The site of the rash puts us on the track. The rash is located on the exposed parts.

(a) hands and forearms if the offendant material is a solid or a liquid, and if the worker is insufficiently protected.

(b) face and neck if it is a vapor. Generally the rash covers exactly the exposed parts of the skin. On the upper limbs it stops at the edge of the sleeves; on the neck it stops at the neckline and on women forms a presternal V, very characteristic.

As for the rash it is generally a very common irritation of the skin with no specific symptoms. The degree of the skin reaction is in ratio to the intensity and the duration of the irritation. We find all types of irritation: simple erythema, edema, oozing eczema, bullous eruption, exfolative dermatitis, squamous and lichemficated eczema.

Characteristic Lesions of some Occupational Dermatitis

In some instances the rash has peculiar features or locations which give a clue to the nature of the irritant.

(a) I will only mention the palmar "Pastry Dermatitis," not rare in Portland;—acute bullous manifestations which can be seen with any irritants, but more often with rubber and its compounds, and with arsenic;—chronic ulcers of skin and nasal septum due to chrome ("Chrome Holes"), cement, or zinc chloride used in soldering;—late changes of the skin with keratosis and cancer due to arsenic, coal tar or X-rays.

(b) More interesting are the abnormal locations of the rash which invades not only the exposed parts of the skin, but its covered parts. This can be found when underwear becomes impregnated with perspiration and moisture absorbing dusts such as cement. "Cement Dermatitis" is frequently located on back, belt and groins. Some parts of the skin can be affected

with welding fumes and painting solvents. An unusual location is the back of the hands among workers wearing gloves, when dust drops inside the gloves.

(c) In some instances the rash co-exists with respiratory troubles. "Aniline Dye Dermatitis" is frequently aggravated with spasmodic rhinitis and asthma. The same complication is observed more and more often in galvanized iron work since riveting has been replaced by electric welding. Zinc, which is used for galvanization, is volatilized by heat when the iron is welded. Its toxic fumes give rise to the "Metal Fume Fever," also called "Galvo Fever," which starts suddenly with chills, irritations of the skin and the respiratory tract. Welders and tackers of the shipyard are sometimes affected by these troubles in variable degrees. It is a question here of a real accidental poisoning, and it would be only just to compensate all these cases as labor injuries.

(d) I am coming to the more important and more characteristic group of occupational skin diseases, that of "Acne-like Dermatitis." They are due to coal tar, cutting oils or chlore, and are observed more and more frequently in this part of the country.

"Coal tar Dermatitis" is prevalent among road makers. "Cutting oil Dermatitis" affects steel workers insufficiently protected from the oil projected by the machinery and used in cutting and grinding operations.[4] As for "Chloracne," often discussed in recent medical literature, its most important cause is "Halowax," a kind of chlorinated wax used to isolate cables and affecting marine electricians. Halowax has caused, in certain plants, anxiety which is understandable in view of the fact that this rash can be complicated with acute yellow atrophy of the liver; some cases have been fatal.[5]

These three acne-like dermatitis are not identical. Coal tar and cutting oil lesions are essentially those of an acute acne with papules, folliculitis and boils. On the contrary chloracne is formed only of large comedones, so numerous that they can be agglomerated in patches.

With the exception of the above, and a few I have not the time to discuss, occupational dermatitis have no particular characteristics and diagnosis is often difficult.

Complications

These difficulties are often accentuated by complications which modify the aspect of the lesion. These complications are of 2 types: infectious and therapeutic.

(a) Infectious complications. Pyodermatitis are frequent especially among shipyard workers and many occupational dermatitis are superimposed with impetigo. In other cases the superimposed infection is an epidermophytosis or a yeast infection. Speaking of which I have been impressed by the frequency of monilial infection among shipyard workers. Perhaps dust of the shipyard combined with the humidity from the sea is the cause of this infection. Whatever the reason, it sometimes is only necessary to paint with 2% aqueous solution of gentian violet to cure the rash.

(b) Another frequent complication is the overtreatment of the lesions. We all, physicians and nurses of the First Aid room have made this mistake. I have made this mistake often enough myself and the criticisms which I am going to make are aimed at myself as well as at others. Too often occupational dermatitis is treated with ammoniated mercury or sulphur or sulfathiazol or analgesic ointments, when the best treatment is plain talcum powder or calamine lotion. Recently a woman who worked in a shoe factory consulted me. She had suffered from a supposedly aniline dye rash for three months and this rash grew worse although she had stopped work. In fact since the beginning she had applied nupercainal ointment which aggravated her irritation. It was only necessary to stop any kind of treatment, and she was cured in 2 weeks.

One of the most frequent causes of aggravation is sulfathiazol and I have two recent cases on my conscience. I will show you later the photograph of a very curious case. I have emphasized the frequency of complications and difficulty of diagnosis which they accentuate; and this brings us to patch tests.

Patch Tests

The patch test is an important aid in the diagnosis of dermatitis but it is responsible for many errors. "P. T. is based on the theory that if a dermatitis is caused by hypersensitivity to a certain substance, the substance when ap-

plied to an area of unaffected skin of the susceptible individual and left on for a period of time, will cause an irritation of the spot where it touches the skin. In doing a P. T. it is important to know what concentration of certain chemicals can come in contact with the normal skin for a stated period of time without causing a reaction."[6] These concentrations are formulated in Sulzberger's exhaustive table (I counted 830 substances in it), or in the more simple one of Schwartz.[1] They show not only the concentration, but they indicate how the chemicals should be applied (plain or diluted in water, alcohol, oil, perspiration or lanolin). They indicate also the duration of the application which varies from 1 to 6 days according to the chemical.

Generally the sample should be covered with a special adhesive which has a cellophane center. Sometimes no adhesive should be used, the sample being applied drop after drop on the same spot. Sometimes also the sample should be applied on the uncovered skin in order to combine its action with the light's action.

P. T. should be removed as soon as the patient feels any irritation. If it is kept on too long, it can be not only a cause of local but of focal irritation.

We should keep in mind that a positive reaction shows "only that the skin is sensitive to the substance with which it was patched. In order to state that the substance was the cause of the occupational dermatitis we must be sure that the patient was exposed to the substance in the course of his work and presuppose that the patient's skin was also sensitive at the time of industrial exposure.

When negative results are obtained, we must not conclude that the dermatitis is not of industrial origin, because the skin area over which the patch was placed may not be hypersensitive."[6]

Prevention of Occupational Dermatitis

Prevention is the most important factor in the elimination of occupational dermatitis. The basic principle is separation of the irritant from the worker. This may be accomplished by care which in general is taken by both employers and employees. I have the greatest admiration for the industrial effort of this country, and more especially for this part of the country. Industrial centers with large output were created in a minimum of time and despite these hurried improvisations the hygenic conditions in factories and among workers are better than those in France in peace time. Naturally there are certain factors which have been overlooked. For instance:

(a) After work, workers are in a hurry to leave the plants. The bus or the car is waiting and they are to hurry in order not to miss it which would be a serious inconvenience to those who live in Redbank village and even more so in Fryeburg. Therefore, employees do not take the necessary time to clean up at the plant, or if they do it is done in a hurry with harsh cleansers which scrape the skin and are often the cause of dermatitis.

(b) Those who would like to clean up with more care complain that they lack sometimes the means at the plant.

(c) In other cases they handle products which discharge dangerous dusts, and they do not wear either coverall or cap. In one factory in the center of the state where I was called in for several cases of skin irritation, I found women handling a dangerous synthetic resin without wearing special clothes, and their heads bare. In this way they were in contact with the irritating dust 24 hours a day. Therefore it was not surprising that they had a rash. Except for this criticism it is my impression that hygienic conditions are generally good, and when they are deficient, it is more often due to the carelessness of the workers.

What are the protective measures to be taken? There are 2 kinds: personal and collective.

Personal Protection

1. Protective clothing, that is: coverall tightly closed at the neck and wrists, adequate working gloves, caps or hoods covering head and shoulders, goggles when necessary, and finally aprons, indispensable when handling cutting oils.

2. Protective Ointments. There are different types and during years I have tried them, they have always turned out to be useless, if not dangerous. That is a personal opinion, but I

was pleased to discover that that opinion was shared by Dr. Monkhouse. As a matter of fact these ointments which are supposed to protect face and forearms against dust, fumes and germs of all kinds, actually glue them to the skin.

Recently another method has been advised: painting the skin with volatile liquids which, after evaporation, leave the skin covered with a light film called "invisible gloves."[7] Some of these gloves are water soluble, others water insoluble. The former flake off as perspiration accumulates beneath and are not to be advocated. As to the water insoluble gloves, they are difficult to prepare, expensive and dangerous. I tried those on 2 patients, one I never saw again, the second developed a rash on both hands. Consequently I never use either.

3. Cleanliness. In fact the best prevention is cleanliness. After work, the employee should wash with water and a neutral soap. When it is necessary to cleanse the skin of tar, pitch or cutting oils, all three very irritating, it is better to clean with a mixture of sulfonated castor oil with 2% sodium lauryl sulfate. This liquid, recommended recently by Schwartz[4] is excellent. Sulfonated castor oil cleans the skin without removing too much skin oil. As for sodium lauryl sulfate, it is a wetting agent which lowers the surface tension of the cleansing oil and facilitates its spread into the pores of the skin. It also facilitates the removal of the oil by water.

Collective Protection

Cleaning up should be done at the plant. Clothes should be changed there and working clothes left at the plant and washed every day. If they are taken home, contact with occupational dust is not broken. It has been estimated that, at one plant where such a system has been instituted before this war, six cents a day per worker is the cost of furnishing clean work clothes each day.

Selection of Workers

I cannot close the chapter of prevention of occupational dermatitis without mentioning the method of selection of a suitable working personnel by routine pre-employment examination. I quote the *J. A. M. A.*: "It may be advisable to exclude from certain occupations individuals with a history of recent skin disease of the dermatitis or eczema type—those with evidence of present or past dermatitis at the time of examination and those with a type of skin susceptible to dermatitis. For example—workers with dry or ichthyotic skin should not work with solvents and degreasers, and blondes should not work with photo sensitizing agents. A history of previous allergy need not be a barrier."[7]

Last question: Should we use patch tests in routine pre-employment examinations? Jadassohn, Jr., says, "yes." Sulzberger says, "Perhaps."[7] Downing says, "No,"[8] and I think the last is right owing to the uncertainties of patch tests and their theoretical negativity before patient becomes sensitized.

Treatment

I have insisted at length of prevention of occupational dermatitis. I will be brief as to treatment. Plain talcum powder, calamine lotion, carron oil are the best. Sometimes X-rays are helpful. A treatment which is outstanding in coal tar and cutting oil dermatitis consists of application of sulfonated castor oil with 2% sodium lauryl sulfate. I have already mentioned this remedy in the chapter of prevention.

If, in spite of precautions, a worker develops a rash, there is no cause for alarm. Eruptions can appear in new workers; if mild, the worker should be kept at work for 3 to 4 weeks, in the hope of developing an immunity. If this does not occur, the worker should be taken off the job. But that decision should be made only if indispensible in order not to aggravate absenteeism.

Conclusion

I have far from exhausted the subject. It changes from day to day and to keep up with the latest theory we must keep track of the articles which constantly appear in the current medical papers. You will excuse the few criticisms I have made, and I hope you will not think that I have taken advantage of this precious freedom of speech which this country generously allows me.

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*Eye Problems in Industry**

By E. Eugene Holt, Jr., M. D.

The value of Ophthalmology to any industrial program is so essential that a large number of the leading ophthalmologists are becoming interested in this special field. As a result Industrial Ophthalmology has gained deserved recognition too long delayed. A plant of any size, in most industrial areas of America, cannot formulate a health program without including ophthalmology. Standards of visual requirements necessary for efficiency and safety in the various departments of industry have been established. The objectives of these standards are so broad as to enable an employee to be placed in the job for which he is best fitted. Such selections will help the visually efficient and tend to eliminate the misfits with resulting gain to the employer and less disappointment to the employee.

At a meeting of the American Academy of Ophthalmology and Oto-Laryngology in Chicago this fall, an instrument called the Orthorater was demonstrated. An examination of the eyes with this instrument provides an orderly method of investigating the relative importance of vision to the various jobs in the plants and of measuring the visual aptitudes of employees for these jobs. A record is obtained of the central vision of the eyes, alone and together, with and without glasses; muscle tests; color vision; and depth perception. This apparatus can be operated by a non-medical person and the time consumed for the test is about six minutes. The field of vision cannot be taken with this instrument. Perhaps later models will include this important function of vision. These tests are recorded by the Key-Sort Record System, a system devised to obtain quick and accurate information without index or cross index.

Before the war there was an average of two eye accidents every minute. Now with the employment of green help these figures probably will increase to five a minute. In compensation, eye injuries for the same type of accidents are far more expensive than injuries to other parts of the body in terms of disability. The average permanent (partial) disability for all cases was five weeks whereas the average permanent (partial) disability resulting from eye injuries was fifteen weeks—three times greater than all injuries. In general, the average compensable eye injury costs the employer or his insurance underwriter $270.00 for compensation, and $81.00 for medical expenses. In non-compensable eye injuries $9.00 is the medical and nursing cost. Eminent authorities have pointed out that indirect or hidden costs of accidents are four times greater than the costs of compensation and medical services. This means in compensable eye injury the compensation and medical service is $351.00, and this figure multiplied by 4, the hidden cost, is $1,404.00. Multiply this by 60,000 compensable cases, 20% of 300,000,† the estimated yearly eye injuries, the cost is a staggering sum in money alone. To these figures must be added the possible diminution of earning power and the percentage of those becoming public charges or depending upon charity. The remaining 240,000 non-compensable eye injuries at a cost of $9.00 gives a sizeable burden for industry to assume. Such figures have served as a stimulus to devise methods of preventing these accidents. The conclusions of those who have studied the subject are that 90% of such injuries are preventable. To accomplish this a safety program has to be sold from the top down—"Any plant is as safe as its general manager." Judge Gary of the U. S. Steel Corporation was publicized as the father of the safety movement in America. He believed that the million dollars spent for accident prevention, health protection and general welfare activities paid bigger dividends than the same sum invested in the direct process of steel making. An adequate medical service for industrial plants has been outlined and approved by the American Medical Association and the American College of Surgeons. These outlines deserve full consideration and if fol-

* Presented before the Portland Medical Society on November 2, 1943.

† The industrial accident figures just released by the Secretary of Labor would increase this number.

lowed are in the direction of preventable industrial accidents. Many medical schools, realizing the need of trained medical men to carry out this important program, are offering post-graduate courses in industrial medicine. The didactic teachings are supplemented by practical experiences in large industries. Already some of the physicians receiving this training have accepted full-time positions and more physicians are bound to be attracted to this valuable branch of medicine.

Electric Ophthalmia, commonly "flash" is a burn of various degrees to the eyes from the arc of an electric welding apparatus. The infrared ray of the arc causes these burns. The intensity of the burn and the structures of the eye involved, depend upon the power of the arc, the length and distance of the exposure. In the milder cases the infra-violet ray of the arc causes a slight burn of the cornea. In such instances the central area usually is slightly hazy due to an edema of the corneal epithelium. This is readily seen by the slit lamp. In more severe cases there may be vesicle formation in the epithelium which later ruptures with the danger of secondary infection; and in the most severe cases where the exposure is within three feet, there is in addition an edema of the retina. Clinically these changes are manifest forty-eight hours after exposure. In the milder form burning, smarting, lachrymation, photophobia with blepharospasm, are present. In the severe cases extreme blepharospasm is the predominant feature. In addition a common complaint is a change in vision often exaggerated to complete blindness. A secondary infection of the cornea may cause an undesirable complication in the severe burns and precautions always should be taken to avoid this. The question continually is being raised as to whether it is possible to have an electric burn in one eye. The concensus of opinion is that one-eye burns do not occur unless the protective lens is defective on one side. In my experience "Flashes" is much abused and over-rated by the patient in attributing this as a cause of the disabling eye condition whether active or inactive. Thus the employees have capitalized on "Flashes" and much to my surprise some physicians have blindly subscribed to this, postulating many theories of possible damage to the eyes. The fact remains that there are very few instances where "Flashes" *without complication* have produced any permanent loss to the visual efficiency.

Treatment: Rest, cold packs or at times hot packs, local anesthetics such as pontocaine, butyn and holocaine, best administered in the form of an ointment; antiseptics such as Metaphen and Sulfadiozole and Sulfadiazine drops; together with bandaging of the eye. Usually in 24 to 48 hours the acute stage of the burn subsides and in case this does not occur, look for complications. Should a secondary infection of the cornea — an ulcer — develop, it should be treated promptly and it may be necessary to hospitalize the patient.

In addition to the local treatment often it is advisable and necessary to administer some form of sulpha drugs internally. Where there is retinal edema, rest of the eyes is imperative until the edema entirely subsides.

Flying particles set in motion by hand tools, machinery and various unclassified sources cause more than fifty per cent of eye accidents. The severity of such accidents depends upon the size of the foreign body and its velocity. Fortunately the foreign body usually is small and lodges on or in the superficial layers of the cornea. The most dangerous accident to the eye is the penetration by a foreign body which is retained in the eye. In every case there always is present the possibility of a secondary infection, and the danger to the integrity of the eye depends upon the severity of the infection, the promptness and character of early treatment. A foreign body resting on the surface of the cornea can be wiped off easily, but if the foreign body is embedded in the corneal tissue it requires experience in its complete removal including the burned area or ring rust of corneal tissue, avoiding as much as possible the denuding of corneal epithelium and the damaging of corneal tissue. If this natural protection of the cornea—its epithelium—is widely denuded or the corneal tissue extensively damaged, healing is delayed, the danger of infection is greater (an ulcer—with a resulting scar and a possible loss of vision depending upon the location and density of the cicatrix), the length of disability is increased, and the discomfort to the patient is considerable. In order to reduce such undesirable complications the experience of an ophthalmologist is needed and should be utilized.

A foreign body which penetrates and is retained in the globe is so serious as to require the immediate attention of an ophthalmologist. In case the accident is so extensive as to destroy the eye, the removal of the eye should be urged for safety and for the avoidance of a prolonged recovery—usually resulting in a sightless, atrophied, disfiguring eye. In less extensive injuries the history is important as it may give information of the nature and the possibility of the foreign body entering and being retained in the eye.

X-ray will reveal the presence of all metallic and some non-metallic foreign bodies, but at times the X-ray may be uncertain of the exact location. In case of doubt the giant magnet should be used and the X-ray repeated. The second X-ray, in case the foreign body is magnetic, may show a different and more favorable location. At any rate no attempt should be made to remove a foreign body unless the examinations indicate beyond any doubt the presence of a foreign body inside the eye. A magnetic foreign body is removed by either the hand magnet or the giant magnet through the cornea or through the sclera, the method chosen depending upon the experience of the operator and the nature of the injury. The removal of a non-magnetic foreign body from the interior of the eye is doubtful and is accomplished only with great risk to the integrity of the globe.

After the successful removal of a foreign body from an eye there may be several unfavorable complications. Some of the more important complications are (1) primary infection, (2) chronic uveitis—usually a fore-runner of sympathetic inflammation, (3) sympathetic ophthalmia, (4) cataract, and (5) detachment of the retina either early or late.

The corneal microscope gives valuable aid in the early diagnosis of such injuries and their complications, especially chronic uveitis and sympathetic ophthalmia. Treatment of the complications will vary according to the conditions present. It should be prompt and always under the direction of an Ophthalmologist.

Warning: The offending injured eye should be removed before sympathetic inflammation appears in the other eye, for if sympathetic inflammation develops it is always difficult and at times impossible to control.

Wearing of goggles, hoods, shields, etc., is a simple means of protecting eyes from flying particles and from burns from electric welding arcs. Goggles should be light in weight, should have non-shatterable glass, and should be properly fitted so as to avoid steaming of the lenses. There are a few instances of foreign bodies lodging on the cornea even when goggles are worn. This probably may be due to the faulty fitting of the goggles or to the vulnerability of the perforated protective sides of the goggles. The greatest obstacle to the wearing of goggles is the lack of education and appreciation of the necessity for such protection. Rules for the use of goggles are valueless unless strictly enforced. This requires an active, directing head who is aware of the potential dangers of eye accidents and who will disseminate this knowledge among the personnel of an industrial plant even in the time of an emergency. Consequently the driving force for a safety program must come from the tops down. An instance where goggles might have prevented an accident is as follows: An employee was transferred from one job where he wore goggles to another where nothing was said about goggles; and soon after starting his new work an accident from a flying piece of metal resulted in the loss of one eye. This great loss probably would not have happened had goggles been worn and indicates perhaps a lack of intelligence of the worker and a great need of continuous proper supervision in the use of goggles to prevent eye accidents. In many modern plants the management is exerting great effort to provide workers with facilities to insure proper first aid and subsequent necessary treatment. This valuable service together with the accident prevention program which is being promoted by insurance companies in coöperation with industrial management, if strictly adhered to by both employer and employee, will tend to minimize the number and extent of injuries.

We would not have too many beds for tuberculosis but too few if funds were available for adequate case finding in most areas. — L. J. Webster, M. D., *Minn. Med.*

The Anemias

Some Basic Concepts

Lloyd H. Berrie, M. D., Caribou, Maine

The blood may, clinically, be conceived as a vital organ. Blood is truly life, for without normal red cells oxygen cannot be carried to the tissues.

The plasma, or "watery" element of the blood contains large amounts of proteins, immune bodies, sugar, salts, chloresterol and other factors. The solid or cellular elements are made up of enormous numbers of tiny globules, called red cells, with fewer white cells and platlets. The formation of these cellular elements occurs largely in the well protected "caves" of the bone, the bone marrow. Here, growing in profusion, are the three types of cells, the red cells, white cells (except lymphocytes and some monocytes) and platlets.

The red cell, with which we are most concerned here, goes through its entire growth cycle in the bone marrow and there loses the distinguishing feature of any cell, the nucleus. Now, it is actually not a cell, but a chemical globule containing the all important chemical haemoglobin.

The average red cell count in the adult male is 5.5 millions per cubic millimeter. In the adult female it is 4.8 millions. *Individual variations of nearly one million per cubic millimeter above or below these figures may occur in health.* The red count may also show considerable variation during the 24 hours; fluctuations of 10 per cent are common, and of 20 per cent are not unknown.

The average haemoglobin content of the blood is 15.8 grams per 100 cc. for the male. In the female it averages 13.7 grams. In 90 per cent of normal males the range is 14 to 18 grams, and in females 12 to 15.5 grams. Daily variations of at least 10 per cent of these figures occur. 1 gram of haemoglobin when fully saturated combines with 1.34 cc. oxygen, so that the haemoglobin concentration is an index of the oxygen carrying power of the blood.

Usually, haemoglobin concentrations are expressed in relation to an arbituary standard called "100 per cent haemoglobin," and not in grams per 100 cc. of blood. The expression "per cent haemoglobin," is therefore meaningless unless the standard adopted is known, and in any case is a most misleading and undesirable form of terminology that ought to be abandoned. For Haldane, 100 per cent haemoglobin means 13.8 grams per 100 cc.; for Sahli, it means 17.3 grams per 100 cc. The Tallvquist determination of per cent haemoglobin has little or no place in modern medicine as a basis upon which to make diagnosis or to formulate treatment.

The bone marrow, in order to manufacture red cells efficiently, must be equipped with proper raw materials, both for the cell itself and for the cells' haemoglobin. At least protein, iron and vitamin B-complex are essential. Ascorbic acid—vitamin C—and other substances, including copper and thyroxine may also be of importance.

The protein of meat, liver, and egg yolk are better for this purpose than those of milk, cheese, and the vegetables, such as beans and peas. The better proteins also contain the largest amounts of iron.

These materials can be utilized only if they are properly digested and absorbed by the intestines into the blood stream. The stomach must have plenty of hydrochloric acid and another substance called by Castle, the "intrinsic substance." The hydrochloric acid seems to be the predominating factor in the digestion of iron-containing foods and Castle's enzyme converts protein products into a material which helps build the red cell itself. Obviously, if the stomach is seriously diseased, anemia may well develop. Similarly, the absorptive function of the intestines must be intact, a function that could not work well, for example, with chronic diarrhea or dysentary.

Classification

Anemia indicates a reduction in the blood of either haemoglobin or red cells or both. We

know now that all anemias are secondary to some cause and therefore the classification "primary anemia," and "secondary anemia," is obsolete.

There are three fundamental causes for anemia: lack of supply, excessive loss of or destruction of red cells, and defective formation in the bone marrow itself.

The tendency in recent years has been to base classification on cell size and volume since by this means good clues are immediately given toward the solution of the cause of the anemia. Roughly this is done by the following methods of study:

Haemoglobin determination: If done by the Sahli method, carefully, it will be satisfactory for clinical use.

Mean Corpuscular Volume: This determination of the average volume of the red cell is an important diagnostic procedure, particularly in the diagnosis of the macrocytic anemias. It is determined by first obtaining the volume of packed red cells per unit of blood. A Wintrobe 1 cc. hematocrit tube is usually used. Oxalated blood is centrifuged and the volume of packed cells noted. This figure per 1,000 of blood (normally 460) is divided by the red cell count in millions, the resultant figure being the mean or average corpuscular volume in cubic micra. Example: Hematocrit (volume of packed red cells per 100 cc. of blood) 46; red count, 5 millions; M. C. V., $\frac{46 \times 10}{5.0}$ equals 92. Normals (Wintrobe) are: Normocytic 84 to 92; Macrocytic, greater than 94; Microcytic, less than 80 cubic micra.

Color index: This expression indicates the amount of haemoglobin in the red cell compared with the normal amount. A color index of 1 indicates that each red cell contains the normal amount of haemoglobin. To obtain the color index the per cent haemoglobin is divided by the per cent corpuscles. The normal number of red cells is assumed to be 5,000,000 for each cubic mm. or 100 per cent. The percentage of red cells is found by multiplying the first two figures of the red count by two.

The test offers an additional clue to the type of anemia present in that in the macrocytic (hyperchromic) anemia, such as pernicious anemia, the color index is usually greater than 1, while in the microcytic anemia (hypochromic), it is usually greatly under 1. In order for this test to have any worthy significance the haemoglobin determination must be accurate—preferably determined by a careful Sahli test.

The anemias may be classified as being either (1) Microcytic; (2) Macrocytic; or (3) Normocytic.

The microcytic anemias, which are usually hypochromic (relatively low in haemoglobin) as well, are characterized by a small average cell diameter and a low average mean corpuscular volume (less than 80 cubic micra). This anemia is associated with a deficiency of iron in the body.

Infants kept too long on a purely milk diet (milk contains practically no iron); poverty-stricken mothers unable to purchase meat or green vegetables; the eccentric type that subsists on tea and toast; the individual with chronically bleeding peptic or duodenal ulcers or hemorrhoids—all these will sooner or later become victims of a state of anemia of the iron deficiency type—what used to be called "secondary anemia."

Particularly vulnerable are adolescent girls and middle-aged women. The skin becomes flabby, wrinkled and pale; the tongue red and shiny; the hair dry and gray; the finger nails brittle, rigid and flattened. Weakness, easy fatigue, palpitation of the heart and digestive symptoms are common.

Many of these patients show a lack of stomach hydrochloric acid indicating some difficulty in digesting iron-containing foods. In some, excessive loss of blood during menstruation, or many pregnancies with or without miscarriages are the contributing factor.

Haemoglobin concentrations as low as 20 to 30 per cent of normal may result. The response to adequate dose of iron in this state of chronic iron deficiency is dramatic. The haemoglobin may rise 7 to 10 per cent or more in one week, and with it soar the spirit and sense of well being. Usually the iron therapy must be continued in order to prevent a relapse. If there is excessive bleeding, this must be stopped. This is microcytic anemia. It is an iron deficiency. Probably the best practical therapeutic agent to use here is ferrous sulphate, grains 3 to 5, three times daily, given after meals. In the face of severe enteric tract disturbance, green

iron and ammonium citrate, U. S. P. XI, .1 to .2 Grams intramuscularly can be given daily for 30 injections or more.

In temperate or colder zones, the most common of the macrocytic anemias is "pernicious anemia" or Addisonian pernicious anemia. Other pernicious types occur and are usually associated with a deficiency in Castile's antianemic principle. Here the stomach is faulty chiefly; for years it has failed to digest the better proteins properly. The liver is pretty well depleted of its stores; the bone marrow does not get its raw material and anemia develops. The whole body suffers, too. The hair greys early; the tongue loses its normal coat and is easily irritated; bowel function is disturbed; peculiar "pins and needles" feelings bother the fingers and toes; and, after a while, the legs become stiff and crippled. The bone marrow goes on a strike and produces fewer and fewer cells, and these are misshapen and unusually large. The red cell count goes down and down and may reach as little as a million. At the same time the skin takes on a lemon hue and jaundice develops. (Cancer of the stomach can cause an identical picture!)

The treatment is to give adequate amounts of liver, liver extract or stomach extract. All are effective. Liver may be taken raw, ground in a tomato juice cocktail or broiled. The best method is to give liver by intramuscular injection because then accurate control over dosage is obtained and we also know that it is being absorbed. These patients should always be kept under strict observation because of the threat of severe damage to the central nervous system. Liver, although it is brilliantly effective, does not cure, but it keeps the condition at bay.

Liver extract is by no means a cure-all. It has no value whatever in the presence of microcytic anemias due to iron deficiency, and is useless in the anemia which is so common in sallow, neurasthenic women. Its routine use in any and every case of anemia is not only expensive and unwarranted but is often productive of of much delay in the discovery of such fundamental causes of anemia as hidden hemorrhage, cancer, thyroid deficiency and others.

The same criticism holds true for the numerous fancy named and fancy priced preparations which flood the markets and which contain (among other things) iron, liver extract, vitamin B complex, copper, manganese and so on. Liver extract is of value in very few conditions —uncomplicated macrocytic anemia; especially Addisonian anemia, and the occasional macrocytic anemia of pregnancy.

The macrocytic anemia of cancer of the stomach can simulate that of Addisonian pernicious anemia quite accurately. In the presence of the least suspicion of cancer, the patient should at least have a gastric series of X-rays including fleuroscopy.

Macrocytic anemia may also occur with cirrhosis of the liver. Here the cell size is not markedly varied and liver disease is apparent. The anemia of myxoedema and, infrequently, diabetes, may cause diagnostic error. Leukemia with low white count may cause an anemia similar to the macrocytic type. The same may be said of idiopathic "aplastic anemia." In the former a bone marrow biopsy and a therapeutic test with liver extract may be helpful. In the chronic aplastic anemias there are no central nervous system signs and glossitis is uncommon.

The anemia of pellagra may resemble Addisonian pernicious anemia. Here there is vitamin B deficiency. In temperate and colder zones this deficiency is commonly associated with chronic alcoholism. The tongue becomes fiery red, sores develop in the corners of the mouth, the forearms and hands are the site of scaly eruptions, the mind becomes affected, and anemia develops. Since crude liver preparations contain some of the B complex it may help some but is not nearly so effective as large amounts of the vitamin itself. In the tropics, spruce can cause a similar type of macrocytic anemia.

The normocytic anemias are most frequently due to chronic poisoning from some such substance as benzol or related chemicals. It occurs in synthetic rubber plants or where rubber solvents are used. Paint removers, dye cleaners and other volatile chemicals may contain large amounts of benzol. The treatment is prevention. Once established this anemia is fatal. Many cases resembling normocytic anemia that are aplastic in nature may be due to invasion of the bone marrow by malignant tumor or by leukemia.

Continued on page 56

The President's Page

Sacrifice?

The first few weeks after Pearl Harbor, patriotism among us, on the home front, was fervent. We were willing to make personal sacrifices temporarily, eat less food, wear out our old clothes and postpone acquiring all but the essential attributes of life, until our enemies were trodden under foot, and the sky was again blue.

We willingly attended meetings for Civilian Defense, obeyed the beck and call of the Air-raid Wardens, made innumerable examinations of draftees, and bought some War Bonds.

But now, after two years of war in which our sons and other men's sons are really giving their all, even life itself, we at home grumble because the cost of living has materially increased; grumble because we are asked to buy a few interest-bearing War Bonds; grumble most because we have to do more work than we did when the younger men, now at war, were carrying part of the burden.

I believe we are too hypocritical in our attitude of desiring and demanding that we be allowed to live as we did in peace time.

I am also of the opinion that this war should be paid for now by the ones here at home away from all danger, instead of leaving it to be paid for by those who are fighting for us.

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Editorials

Compulsory Prepayment Medical Care Plans Inadequate

Compulsory prepayment plans for medical care are anchored to financial, administrative and political considerations, to which the quality of medical service must be made to conform whereas medical society prepayment plans make good medical care the stable element to which all else must be adjusted, *The Journal of the American Medical Association* for February 12 declares in the fourth of a series of editorials discussing the Wagner-Murray-Dingell Bill.

The Journal says:

"The basic argument for compulsory sickness insurance is the financial one — that the cost is with certainty distributed in time and over a larger body of people. Compulsory sickness insurance, according to such evidence as is available from other countries, inevitably deteriorates the quality of medical service by spreading it more and more thinly to meet the financial resources and polluting it by politics. Admittedly, like all insurance, it spreads the expense of unanticipated illness.

"Can the fundamental objectives of spreading expense be attained without compulsion? The House of Delegates of the American Medical Association has repeatedly adopted resolutions encouraging state and county medical societies to organize experimental prepayment plans. Many such plans—at least twenty—several of them statewide, are now in operation or in process of organization. The first was begun about six years ago; now approximately a million members are receiving medical care through such plans.

"Prepayment plans for hospitalization, also endorsed by the House of Delegates, have expanded in a decade to nearly every state and now include some fifteen million members. Medical society prepayment plans have coöperated with hospital plans as well as with the Farm Security Administration, Social Security, Care of the Indigent, Federal Housing Projects and Industrial Medical Plans. The functioning of these relationships has not always been smooth nor have relations with other agencies been without occasional friction. There have been conflicts, mistakes and disagreements. Those who think that compulsion removes difficulties will be quickly undeceived by a glance at the volumes of legislation, litigation and regulations that have sought to patch defects in compulsory systems. Medical society prepayment plans have also had their administrative and financial difficulties, but at least the prepayment plans under auspices of medical societies seldom permit the medical service to deteriorate in quality. Medical society plans concentrate on the minimum interference with mutual free choice between physician and patient.

"Prepayment plans are still experiments — compulsory no less than voluntary; both are evolving and changing. Compulsory plans are anchored to financial, administrative and political considerations, to which the quality of medical service must be made to conform. Medical society prepayment plans make good medical care the stable element to which all else must be adjusted. Medical society plans grow and develop with the progress of medicine and the health needs of the public. Compulsory plans are imposed by forcible revolution, fixed by law and changeable only through political pressure. The vested interests which they create and protect are those of partisan politics. The health of the public and the progress of medical art and science seem to be secondary to administrative considerations, notwithstanding the protests and iterations of legislators that they are concerned only with the delivery of medical service. Had they been so concerned they would at least have consulted with the medical profession as to possible technics by which the desirable objectives could be secured."

Warns Against the Indiscriminate Use of Sulfathiazole Ointments

The indiscriminate use of sulfathiazole and other sulfonamide ointments "in minor conditions, when less harmful drugs are adequate, should be discontinued," Roy A. Darke, M. D., Assistant Surgeon, U. S. Public Health Service, New York, declares in *The Journal of the American Medical Association* for February 12. "With the widespread publicity being given to these preparations," he continues, "it would seem desirable to prevent or discourage their sale except by prescription."

Dr. Dark says that "the recent widespread use of sulfathiazole ointment has revealed cases of sulfathiazole sensitivity. My aim in this paper is to call attention to the degree of sensitivity to sulfathiazole ointment existing among the general population. . . ."

Reporting on a group of 218 patients who were treated topically with 5 per cent sulfathiazole ointment, he says that sensitivity was found to be present in 12 cases (5.5 per cent). This seems to be in approximate agreement with the findings reported by other investigators, both in the topical and oral administration of the drug.

The permanence of the sensitivity in Dr. Darke's group is not known, he says. The contact dermatitis (skin inflammation) in each case disappeared when the ointment was no longer applied. The healing of the condition being treated, however, seemed to have been definitely slowed.

"Because this sensitivity may preclude the use of the drug in the therapy of such diseases as meningitis, pneumonia and gonorrhea, it is important that sulfathiazole and other sulfonamide preparations be used topically only when a specific need for them can be justified," he advises.

A. M. A. Committee Acts to Solve Problems of Improved Postwar Medical Care

Three moves aimed at solving two of the most important problems in providing a better post-war distribution of medical care—a wider and more appropriate distribution of hospital and diagnostic facilities and an efficient means for providing for the location and relocation of physicians in the post-war period, have been made by the Committee on Post-war Medical Service of the American Medical Association, *The Journal* of the Association reports in its February 12 issue.

At a recent meeting of the Committee it was voted to recommend to the Board of Trustees of the Association that the Board look into the desirability of establishing an agency for disseminating information on the location or relocation of physicians in the post-war period.

The report points out that "Inasmuch as a wider and more appropriate distribution of hospital and diagnostic facilities would influence decisively a satisfactory location or relocation in the post-war period, the Sub-committee on Location and Relocation . . . was authorized to explore the subject of hospital and diagnostic facilities and the extension thereof as an effective measure in the better distribution of medical care."

In its third move the Committee authorized the sending out of a sample, or pilot, questionnaire of 3,000 copies to physicians in the armed forces. The purpose of the pilot questionnaire is to determine the best form of inquiry as to the probable nature of post-war needs of large numbers of physicians in military and governmental service.

Committee on Conservation of Vision

*Glaucoma**

Glaucoma is a progressive disease and if allowed to take its own course inevitably ends in blindness.

Early Diagnosis of Glaucoma is important in order to preserve the vision and to avoid the disastrous consequences when treatment is deferred until late in the disease.

Glaucoma may occur at any age but the most common Glaucoma period is after forty. The onset may be acute but at times, *especially in the simple or non-inflammatory type,* the beginning is so insidious and so masked that it frequently is mistaken for other ocular diseases. This error in diagnosis may exist even when the Glaucoma is so advanced that it may be too late for treatment.

Glaucoma is characterized by an increase in the Intraocular Pressure, variable at first, but tending to a constant elevation as the disease progresses. From this increase in the intraocular pressure all the essential symptoms of Glaucoma are derived.

Types of Glaucoma:

1. Primary or Acute (Incompensated) Glaucoma.
2. Chronic Inflammatory (Incompensated) Glaucoma.
3. Simple or Non-inflammatory (Compensated) Glaucoma.
4. Absolute Glaucoma.
5. Hydrophthalmus (Buophthalmus).
6. Secondary Glaucoma.

* First of a series of short articles on Glaucoma by the Committee on Conservation of Vision of the Maine Medical Association.

The Anemias—Continued from page 52

One often hears patients remark that they are being "injected" for "anemia" or "low blood pressure." "The doctor just tested my blood," they may say, "and it was only seventy." Somehow such remarks are disturbing. A recent correspondence regarding this with one of our leading haemotologists brought a reply from him that is significant. "I heartily agree with the sentiments as expressed in your letter and I have often stated them openly at various medical meetings, but with little or no effect. It would seem that nearly everyone with any type of real or imaginary anemia, neurosis or neurasthenia has injections of liver, or liver and iron. The ones that don't get it are often the ones with true pernicious anemia. These are usually diagnosed as cancer, nerve disorders, indigestion, colitis, etc. I have recently had eight fresh cases of pernicious anemia in none of whom was the diagnosis made."

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Maine Public Health Association — Women's Field Army

April Is the Month

In April the Maine Public Health Association coöperating with the National Tuberculosis Association will launch its 17th Annual Early Diagnosis Campaign for the Prevention of Tuberculosis.

In April the Maine Division of the Women's Field Army will put on its Annual Drive for funds.

Both of these Campaigns have a common purpose, the immediate control and ultimate eradication of Tuberculosis and Cancer. Control is possible only through finding cases early and getting them under treatment.

The 1944 objective of the Early Diagnosis Campaign is the promotion of Chest X-rays for War Essential Workers, on the farm, in industry and in business. To focus attention of the public on Tuberculosis through April not for fund raising but to render a service of popular education is the special task of tuberculosis associations in Maine and throughout the United States. Community leaders may learn about how X-ray tells the story through three pamphlets entitled: "Let's Take Their Pictures," "X-ray Facts for Teachers" and "Industry and Tuberculosis." Others will learn through the two-page leaflets entitled "John Doe" and "Sam Smart." The posters, exhibits, and radio transcription featuring Robert St. John, the well-known commentator, will lend added emphasis. All Early Diagnosis Campaign material is free and may be secured through the office of the Tuberculosis Association nearest you. The 1944 Campaign platform —In War, A Patriotic Duty; In Peace, Plain, Common Sense—is a reminder that an X-ray for everyone is the first step in finding Tuberculosis early.

The Women's Field Army of Maine provides an educational program and assists indigent patients needing X-ray or Radium Treatment for Cancer. The six Tumor Clinics are located at the Maine General Hospital, Portland; Central Maine General Hospital, Lewiston; Eastern Maine General Hospital, Bangor; Sisters' Hospital, Waterville; Thayer Hospital (Diagnostic), Waterville; St. Mary's General Hospital, Lewiston. Any doctor has the privilege of sending his patients to any of the approved clinics for diagnosis and treatment. In 1943, over 700 new patients reported at the clinics; of this number over 400 were declared non-malignant, thus convincing one that both Maine's doctors and laymen are alert to the danger signals. Since 1937, over 1,700 patients have received help, every county being represented. No applicant has been refused. This year the Women's Field Army is extending the scope of its activities by providing transportation for indigent tumor patients to the clinics, and by helping to provide for each approved clinic a follow-up worker who will contact patients assisted by the Women's Field Army to make sure that instructions are being carried out and that the patient returns to the clinic for re-examination and further treatment. Plans are also being made for a post-war progam.

The time to fight Tuberculosis and Cancer is Now!

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County News and Notes

100% Paid Membership for 1944
Piscataquis County Medical Society

Franklin

The annual meeting of the Franklin County Medical Society was held at Farmington, Maine, December 5, 1943.

Officers elected for 1944:

President, Albion E. Floyd, M. D., New Sharon.

Vice-President, Cecil F. Thompson, M. D., Phillips.

Secretary-Treasurer, George L. Pratt, M. D., Farmington.

Delegates to the 1944 annual meeting of the Maine Medical Association: Drs. Pratt and Thompson.

Censor for three years, Dr. Thompson.

The Society unanimously adopted a resolution condemning the Wagner-Murray-Dingell Bill (S. 1161).

GEORGE L. PRATT, M. D.,
Secretary.

New Member

Knox

Charles J. Watson, M. D., Thomaston, Maine.

Notice

Correspondence

Navy Department
office of
NAVAL OFFICER PROCUREMENT, BOSTON
North Station Office Bldg.
150 Causeway Street, Boston 14, Mass.

1 March, 1944

Dr. Roland L. McKay, State Chairman
Procurement and Assignment Service
284 Water Street
Augusta, Maine

Dear Doctor McKay:

Due to the urgent need for physicians in the Medical Corps of the Navy the maximum age limit for specialist medical officers has been raised from 50 to 55 years of age. This office will be glad to receive applications from physicians who have not yet reached their 55th birthday.

I quote in part from the official communication as follows:

> **"Authority is hereby granted to forward applications for appointment in Class MC-V(S) of individuals whose physical qualifications justify their appointment for limited shore duty only x if approved it is intended to appoint these officers to duty in the naval dispensaries, navy yards, naval training stations, and to the navy and marine corps recruiting service, thus making available for sea and foreign assignments physically and otherwise qualified medical officers now detailed to this type of duty x."**

I shall appreciate your giving this announcement as wide spread publicity as possible.

Very truly yours,
/s/ J. P. MONKS,
J. P. MONKS,
Commander Mc-V(S) USNR,
Senior Medical Officer.

Occupational Diseases of the Skin in Maine—Continued from page 46

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Book Reviews

"A Textbook of Medicine"
(Sixth Edition)

Edited by Russell L. Cecil, A. B., M. D., Sc. D., Professor of Clinical Medicine, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician, Bellevue Hospital, New York City. Associate Editor for Diseases of the Nervous System, Foster Kennedy, M. D., F. R. S. E., Professor of Clinical Neurology, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician in Charge, Neurological Service, Bellevue Hospital; Consulting Physician, New York Neurological Institute.

Sixth Edition, Revised and Entirely Reset. 1566 pages with 195 illustrations.

Published by W. B. Saunders Company, Philadelphia and London, 1943. Price, $9.50.

The first edition of this book was published in 1927 and now it has been found necessary to publish the sixth edition. This book has been thoroughly revised in the light of recent advances in medicine. 154 American teacher specialists have contributed to this new sixth edition. 43 entirely new subjects or rewritten contributions are included. New discussions on virus pneumonia, aviation medicine, sea sickness and air sickness are included. It is of special interest to all practicing physicians as well as for the use of physicians in all branches of the service.

"When Doctors Are Rationed"

By: Dwight Anderson, Director Public Relations, Medical Society of the State of New York; and
Margaret Baylous, Therapist, Charleston General Hospital, Charleston, West Virginia.

Published by Coward-McCann, Inc., New York, 1942. Price, $2.00.

Doctors are being rationed and will continue to be as long as the war lasts, but there will be no shortage. A Procurement and Assignment Service has been set up in Washington for the purpose of rationing doctors to the armed forces without disparagement of civilian needs.

This book is divided into seventeen chapters and tells how doctors will be distributed throughout the country and in the armed forces so that no one will be without adequate medical care.

Have You Paid Your 1944

State and County Dues

The Journal
of the
Maine Medical Association

Volume Thirty-five Portland, Maine, April, 1944 No. 4

The Common Cold

Lloyd H. Berrie, M. D., Caribou, Maine

It has been reliably estimated that in this country alone the common cold is responsible for a yearly outlay of somewhere between two and three billion dollars. Colds and their complications cause more disability and loss of time from work than all other diseases taken together.

Cause of colds. There seems to be conclusive evidence since the investigation of Kruse, of Leipsiz[1] in 1914, that a filterable virus is usually responsible for the common cold infection. Many later investigators (Foster, Dochez, Long, Powell, and others) have confirmed his original observations.

The virus infection is of short duration (three or four days); however, secondary infection usually follows from bacteria ever present in the nose and throat of healthy individuals. These bacteria now become opportunists and carry the disease into a secondary phase through their ability to penetrate the host's weakened defenses.

Symptoms and signs. The virus stage of the acute cold invariably causes stuffiness of the nose, sneezing, and watery discharge, but no elevation of temperature. It lasts three or four days. At the very onset the temperature is apt to be subnormal. When secondary infection occurs the nasal discharge becomes thick and yellow. This stage usually lasts two or three weeks.

Influenza is a distinctly separate entity caused by a different germ. Influenza has a sudden onset with fever, headache, and neuro-muscular or gastro-intestinal manifestations.

Prevention. Nature has provided defense barriers against invasion through the nose. The vibrissae or tiny hairs at the nostril entrance, the mucous coating of the nasal mucosa, and the hair-like cilia of the nasal mucous membrane.

The vibrissae act as filtering barriers to the foreign inspired material. The mucous glands of the mucous membrane, which secrete about one liter of moisture in 24 hours, provide a protective coating to the mucous membrane. The cilia by means of their constant wave-like motion carry foreign material to the pharynx where it is swallowed and destroyed in the stomach.

Indiscriminate use of drying, mentholated, creamy or oily nose medications greatly subdue the local defense barriers and enhance the probability of virus infection or subsequent second-

ary infection. Despite these defences it is, indeed, practically impossible to avoid exposure to the common cold. Eskimos who had never had the slightest evidence of colds invariably were infected when coming in contact with white men who were on expeditions in the North.[2]

Advice as to what to do to prevent colds are multiple and bazaar. Miller[3] wrote; "Grandmother used to suggest that we wear bags of asafetida around our necks. Mother insists on our keeping our feet dry and warm. A lumberjack sews himself up in red flannel for the winter and is convinced that this, plus a liberal supply of whiskey, keeps him free from colds. A Chicago street cleaner maintained that, 'Nobody that chews tobacco will get a cold.' A taxi-driver said, 'My old lady makes me and the kids wear bags of asafetida around our necks. I never have more than three colds a winter.' And a traffic cop, who was more 'scientific,' replied, 'I take cod liver oil, a large bottle every week through the winter. By the time spring comes,' he says, 'your body is yellow and you smell like a fish and the stuff is oozing out of your pores. But for twelve years I have never had a cold.' "

Chilling. Because of the vaso-constricting effect to the body surface, with its consequent slowing of circulation, chilling is a factor in cold production, as is the persistent exposure to dry, dust-ladened air.

The vitamins have been shown to have no important effect on the number or severity of infections of the upper respiratory tract in individuals who presumably already are on a reasonably adequate diet.[4]

Vaccines for colds are unfortunately widely used. They are frequently known as "cold serums," a false term. Diehl,[5,6] Hauser,[7] Siegel,[8] McGee,[9] and many others, have offered ample evidence to prove that the administration of cold vaccines have little or no scientific value in the prevention of or treatment of colds. Many supervised groups have been treated with every type of vaccine stock orally or by injections. During the same period of investigation, control groups were treated with identical appearing medication, usually normal saline injections or milk-sugar capsules. The duration of treatment averaged one or two years. All individuals were carefully examined in order to rule out conditions such as allergic rhinitis or chronic sinusitis. The control group believed that they, too, were receiving vaccines.

In all of these investigations the majority of the individuals who were formerly subject to frequent attacks of the common cold were greatly freed from this illness during the period of vaccine treatment. However, *an equal number of individuals who had received nothing more than injections of normal saline or capsules of milk-sugar, but who thought that they were getting cold vaccines, responded as well or better than the vaccine-treated group.*

How can one explain these spectacular findings except in terms of suggestion and psychosomatic medicine; that vastly uncharted sea, so rich with hidden treasures (and so generally neglected by modern medicine and medical research).

Millions of dollars are spent annually for nose drops, nasal sprays, mouth washes and gargles, none of which can be scientifically catalogued as being preventative to the common cold, and some which can be shown to be actually harmful. Antiseptics that will kill germs in a given time in a test tube are useless unless they act almost instantaneous in the nose or mouth, or if they have an instant lethal effect upon bacteria found in these cavities and no injurious effect on the living cells of the individual. Such an action is highly improbable. There is however, some inconclusive evidence that the bacteriostatic action of some of the sulfonamides, when used in proper concentration and PH against healthy tissue, may have preventative action against some infectious organisms. But as yet it is too early to follow the exaggerated claims that appear in all but highly conservative medical literature.

Treatment. Bed rest. This is the best advice and treatment since it provides warmth, increases resistance, and protects others from infection. Unfortunately, however, few people who do not feel generally ill will follow advice and stay in bed.

Hot baths. At the onset of virus infection, when the nose first begins its watery discharge, and the temperature may be found to be subnormal, a deep hot bath followed by bed rest, even if only for two or three hours, will so elevate the body temperature, increase circulation to the body surfaces, and increase metabolism and resistance, that the attack may often be beaten off before it can gain much ground. It is remarkable how quickly the nasal airway responds to the hot bath.

Drugs. About 13 years ago, Diehl[10] made the observation that morphine gave prompt and effective relief in individuals who had acute head colds. The effect was so constant that a careful study was made with a large group of students who had acute colds. One-half of these students were given drugs, while the other half were given identical-appearing "medication" containing milk-sugar. It was not long before it was distinctly evident that opium derivatives were valuable for their ability to either abort the acute cold or diminish its severity and duration.

Since morphine is toxic and habit forming it is obvious that this drug would have no place in the every-day treatment of the common cold. After long experimentation these investigators found that codeine and papaverine, used together, proved to be nearly as efficacious as morphine, and decidedly less toxic. Both are derivatives of opium but chemically different. A commercial preparation, called Copavin, is available. It consists of one-quarter grain codeine and one-quarter grain papaverine. Diehl and his co-workers found the following method of medication to be satisfactory. "For an adult, one tablet after meals, and two at bedtime; or one tablet every three hours and two at bedtime. The dosage should be regulated according to the severity of symptoms and the reaction of the patient to the medication. If symptoms are severe, two tablets are given for the first and second doses, and three instead of two are given at bedtime. For children the dosage must be determined according to size." It should be borne in mind that copavin must be given early, during the onset of the virus infection (watery, nasal discharge), in order to expect good results.

In his "Confession of an Opium Eater," Sir Thomas DeQuincey said, "It is remarkable that during the whole period of years through which I had taken opium, I never once caught a cold, as the phrase is, nor even the slightest cough. But after discontinuing the use of opium, a violent cold attacked me, and a cough soon after." Jean Cocteau, in his "Opium. The Diary of an Addict," wrote; "Opium is a season. The smoker no longer suffers from changes in weather. He never catches cold. . . . Without opium I am cold, I catch cold. . . ."

Diehl and his co-workers listed the following as being of little or no value: Aspirin, calcium and iodine, halibut liver oil, amytal, ephedrine, atropine, aspirin-phenacetin-caffeine compound, and soda.

Soda was given in sufficient dosage to produce much more alkalinization than is produced by the various fancy-priced preparations obtained at drug stores. The results were the same as those obtained with the milk-sugar. This is what anyone would expect who realized that acidosis does not develop in the body except in serious conditions such as uncontrolled severe diabetes.

Forced fluids. There is no evidence that large quantities of fluids aid in eliminating infection producing toxins.

Cathartics. There is no justification for the belief that catharsis aids in the elimination of "poisons" due to the common cold. In all the armenatarium of the physician, here is one drug group that just about always does what he expects of it. Small wonder then that they so frequently appear on the prescription pad! Patients who take cathartics have longer disability from colds than those who are spared this antiquated therapy.[11]

Alcohol. "Whiskey, brandy, and 'hot toddies'" have long been popular for the treatment of colds. Alcohol itself causes nasal congestion in some people, and many reliable reports show that excessive use of alcohol lowers resistance to pneumonia, a most serious complication to colds. We cannot advise alcohol for the treatment of colds nor can we endorse the directions which frequently go with the prescription;

namely, "that the patient should hang his hat on the foot of the bed and continue the medication until he sees two hats."

Chemeotherapy. Modern medical literature is abundant in reports of investigators dealing with the use of sulfonamide compounds. The weight of evidence supports the view that they are of little or no value in the treatment of the common cold. More recently Patulin has been optimistically reported,[12] but the enthusiasm concerning it was short lived following the report of three investigators shortly after.[13] Patulin is a metabolic product of penicillium patulum.

Regarding the commercial aspect of cold treatments; "The least of the cold soother's worries is his formula. What goes into his pills or syrups or salves is distinctly secondary consideration. How to sell his concoctions is what chiefly worries the aspiring manufacturers of cold remedies. He is in a business where competitors are many and scruples are few. . . ."[14]

The obligations of the physician to his patient who is suffering from the acute common cold is to keep that patient comfortable by methods that have been proven sound; methods that enhance the function of natural body defense mechanisms. To avoid useless drugs and, above all, to guard against and keep alert for indications of serious complications. An early deep, hot bath, followed by a period in a warm bed in an atmosphere of fresh cool air, and the addition of medication with codeine and papaverine, will cause decongestion of the nasal mucous membrane, increase circulation and metabolism, and usually abort the infection. Cold vaccines, the sulfonamides, and the vitamins have been shown by careful investigation to be of little or no value in the treatment or prevention of colds.

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A definite increase in the number of old people dying from tuberculosis has occurred during the past few years. In the year 1940, almost one-fourth of the tuberculosis deaths in the City of Peoria, Illinois, were persons of 60 years or over. As is true the country over, in the age group of 15-34, more women died than men. The hazards of puberty in the girls and the strain and stress of childbearing are chiefly responsible for this fact. The search for tuberculosis among young women offers a fertile field. — M. Pollak, M. D., *Ann'l Rep. Peoria Mun. Tuber. Sanatorium,* 1940.

Progress in the Crusade Against Tuberculosis in Oxford County, Maine, Over a Period of Ten Years (1933-1943)

June Hills Hunter, Tuberculosis Social Worker, Rumford, Maine

Ten years ago there was a long waiting list for admission to the tuberculosis sanatoriums in Maine. No plan for home treatment was in operation. As a result, after the disease had been discovered many weeks and even months might pass before treatment was begun, and the disease often advanced during this waiting period from an early stage to an incurable one. Occasionally a patient died before his turn came to enter a sanatorium. There was likewise no provision for home supervision after the patient returned from the sanatorium. With the approval and support of the physicians of Oxford County assured, the Bingham Associates decided to secure a tuberculosis worker and I was selected to organize the work along somewhat similar lines to those employed in Dr. Pratt's tuberculosis class in Boston with which I had gained experience as a tuberculosis social worker. It was an experiment to be given a year's trial. At the outset I reported in Augusta to Dr. Hanscom, the newly appointed director of tuberculosis work throughout the state, and he appointed me a member of his department to assist the physicians in Oxford County in the care of their cases and to cooperate with the sanatorium physicians. Dr. Hanscom had charge of the admission of patients to the State Sanatorium. Reforms were speedily inaugurated and it was possible to get an acutely ill patient or one with poor home conditions admitted without delay. After Dr. Wakefield became superintendent of Fairfield Sanatorium he was able, by weeding out many old quiescent cases treated at the state's expense for years, to admit a new patient in a short time, sometimes within a few days after application was made.

Dr. Pratt's plan of home treatment by the class method for the poor tuberculosis patients of Boston who could not gain admission to the state sanatorium appealed to the humanitarianism of the late Dr. Worcester, then Rector of Emmanuel Church. "We will finance this class for a year," Dr. Worcester said. That was in 1905, but the year grew to fifteen when the state took over the work. The success of this treatment in the homes of the poor was equal to or even exceeded sanatorium care. Dr. Osler stated in his textbook that the results were as good as any that had been published. The keynote of Dr. Pratt's treatment was "bedrest." This was a new idea as it was life in the open air, not rest, that was then advocated generally and patients even played baseball at the Rutland sanatorium at that time. Bedrest treatment with resulting rest for the lung has become of late years the accepted treatment, facilitated today by lung surgery.

Before going to Dr. Worcester, Dr. Pratt had tried unsuccessfully to interest established health organizations, but it is the private agency or person who ventures into uncharted waters. In the case of the Oxford County tuberculosis work, it is the humanitarianism and generosity of Mr. Bingham that is responsible for the one year's experiment that has continued for ten years.

As this venture was without precedent, there was considerable correspondence with Dr. Pratt as to the best procedure, for the methods of the Tuberculosis Class needed changing in this later time and environment. The first thing that was done was to call on the doctors, acquaint them with the nature of the experiment and offer them free X-rays and other laboratory service for their patients. Some responded with cases, one with as many as six.

In that first year, among 89 families there were 99 patients. 66 were referred by doctors, 9 by nurses, 6 by laymen, and 8 were found through my work.

Some of the doctors will recall the advanced cases who walked the streets, went to the movies, to church, mingled freely with people and even continued to work: LeB—, who thought it "damn nice" that someone wanted to help him but who had no intention of giving up his liberty to go to a sanatorium; G—, a commu-

nity liability who had fathered fifteen, and who finally agreed to go to Fairfield only to get as far as the entrance and come back but who was persuaded to return, this time to remain and die in two months, so far-advanced was he; C—, who continued work in the mill up to three months before he died and whose baby shared his bed— "The babies always slept with their father!" his protesting wife said; Helen, who said it was cheaper to die than to live and who considered a "big dinner" three potatoes and as many cups of tea; Mrs. N. G., with a copious flow of positive sputum, who for years talked of her "asthma," and whose thirty-five grandchildren were checked; John Mc., who didn't believe in tuberculosis care, but who was husband, father, grandfather and great-grandfather to tuberculosis casualties. All these have died, but the tuberculosis legacy they have left behind has been checked.

During that first year many suspects were examined and the question of tuberculosis confirmed or eliminated in persons who coughed, had lost weight, or had other symptoms. After a negative examination, one woman said she had the first good night's sleep in three years, for she had been told that she had a "touch of tuberculosis." I apologized for bringing so many negative X-rays to Hebron for reading, but Dr. Adams said, "I can think of no better news than to tell a person he has no tuberculosis."

In this group of 99 persons:

Number having adult tuberculosis,	43
Number having childhood tuberculosis,	12
Number having no tuberculosis,	44
	99

Number hospitalized (31 adults and 3 children),	34
Number taking home treatment,	10
Number taking modified home treatment,	11
	55

Of the 43 adult cases:

Number dead,	16
Number living after 10 years (25 probably living fairly normal lives),	27
	43

To find the amount of tuberculosis there had been in Oxford County and to find the towns and families where it had been most prolific and recent, the town clerks were called on and lists of tuberculosis deaths compiled. Like most statistics, results were approximate, as years ago deaths from tuberculosis were sometimes recorded as "chronic pleuritis," "pulmonary catarrh," "scrofula," "lung fever," etc. In a fairly recent case of tuberculosis in a 60-year-old man (terminal condition when reported), the cause of his father's death was listed as "chronic bronchitis." The old family doctor was dead, but from the history and finding of subsequent cases (his daughter was one of the first persons in Maine to have the ribs resected) this man undoubtedly died of tuberculosis.

At the beginning, Dr. Wakefield offered to read the X-rays, and he said "tuberculin test all children in tuberculosis families." Then children were reported in families where there had been a death from tuberculosis, and these were hunted up for tests. Some were scattered throughout the county, and Dr. Storey, intern at the Rumford Community Hospital at that time, tested them in their homes and returned later to note the reaction. I remember only one mother who refused this service. She was afraid of what might be found.

Later, Dr. Pratt said "X-ray adult contacts." But from this group the only findings were healed disease of the childhood type, evidence of old pleurisy, or healed adult pulmonary tuberculosis.

Sometimes X-rays were asked for by relatives at a distance and acquaintances. One man was indignant that his own diagnosis was not accepted; another, after listening to a radio talk on tuberculosis, made a correct diagnosis, went to Hebron, and remained there until he died.

After the first year, X-rays were read by the Hebron doctors and also by Dr. Clapp after he was appointed roentgenologist for the Rumford Hospital. The recommendations that are made by the Hebron doctors, which are communicated to the patient's doctor, add value to their readings.

During the first four years, eighteen tuberculosis classes or clinics were held at the Rumford Hospital. Dr. Pratt attended most of them; others attending were Dr. Young of

Skowhegan, Dr. Hanscom from Augusta, doctors from Lewiston, Dr. Adams and Dr. Welch from Hebron, and the local and county physicians. Dr. Adams and Dr. Rowe were the regular attending physicians.

As the work progressed the following technique developed:

1. Tuberculin tests for all contacts and questionable cases, especially children and young adults.

2. X-ray for all reactors, adult suspects, and all members of a family where a tuberculosis case is found.

3. Sputum examination, blood sedimentation rate determination, and physical examination for patients with positive X-rays.

4. Disposal of active case: Sanatorium care is the rule; occasionally home treatment under good and supervised conditions. Usually, doctors do not want the care of tuberculosis cases in the home, and advise sanatorium care for a time at least. Patients who have gone reluctantly to a sanatorium frequently tell how much they have learned, not only about the care of tuberculosis but also about regular living and the importance of health.

5. The undramatic follow-up of cases and contacts by means of repeated X-rays. Some cases treated 10 years ago are still being X-rayed.

6. Hunt for the source of infection.

The following story illustrates this technique: Dr. McCarty said one day, "I wish you'd check John Doe and his family; I think he has tuberculosis." That evening I was told that the man's sister, a nurse, anxious to help him, was coming the next day to take him to her doctor in another town. With that tip, I got to his house the following morning by eight o'clock and took the family of six to the hospital, where all were tuberculin-tested and X-rayed. The examination was hardly over when the sister appeared. She was pleased at what had been done and surprised, for she had no knowledge of the hospital resources. Three active cases were found: one advanced, one minimal, and one of adult type in a nine-year-old child. The three other children were reactors with suspected childhood type of tuberculosis. The active cases were hospitalized, and those remaining at home were kept under observation with restricted activities. Today, after eight years, the patient with advanced disease when discovered (19 months a patient at Hebron) is doing light work, and the others are leading fairly normal lives. All are under supervision to the extent of re-examinations at intervals.

The approximate figures of the 10 years' work follow:

707 persons were given some tuberculosis service:

Number of cases of adult tuberculosis (171 advanced and 73 minimal),	244
Number of cases of childhood tuberculosis,	66
Number of cases of old tuberculosis with questionable activity,	50
Number of cases of healed childhood tuberculosis in adults,	12
Number of cases checked and no tuberculosis found,	335
	707

Advanced Cases—171

Number of recoveries (76 sanatoria and 6 home),	82
Number of deaths (47 sanatoria and 14 home),	61
Number not recovered but still living,	28
	171

Of these 171 cases, 70 were surgical:

Number of thoracoplastics,	18
Number of artificial pneumothoraces,	46
Number of pneumothoraces and thoracoplastics,	1
Number of phrenic nerve operations,	1
Number of nephrectomies (tuberculous kidney),	4
	70

Note: This tabulation does not include cases surgically treated prior to the beginning of my work as the data are not available.

Of the 82 recoveries, 80 cases were pulmonary tuberculosis, one tuberculosis of the spine and one tuberculosis of the kidney.

Of the 61 deaths, 4 were from causes other than tuberculosis.

Minimal Cases—73

Number of recoveries (41 at sanatoria, 22 at home and 5 without treatment),	68
Number under treatment at present,	2
Number of relapses,	1
Suicide,	1
Moved away—fate not known,	1
	73

Among the recoveries was one case of tuberculous peritonitis.

Childhood Tuberculosis—66

Number of recoveries (22 at sanatoria and 41 at home),	63
Number under treatment at present,	1
2 developed adult tuberculosis (one died after marriage and childbirth; one was discharged with condition improved),	2
	66

Old tuberculosis with questionable activity—50

Number of recoveries (10 had sanatoria treatment),	50

6 were rejected selective service men.

2 later died of other causes (heart conditions), both being over 70 years.

Tuberculosis cases first discovered through death notices:

Deaths in sanatoria,	20
Deaths at home,	25
	45

In 10 years there were 107 deaths* from tuberculosis in the county:

Number of deaths in sanatoria or hospitals,	70
Number of deaths at home (11 of these had been at sanatoria),	37
	107

Number of cases reported after death,	45
Number of cases known to me,	62
	107

Number of women or girls,	48
Number of men,	56
Number of small children,	3
	107

Deaths were caused by the following types of tuberculosis:

Pulmonary,	89
Pulmonary and cancer,	1
Miliary,	5
Laryngeal and pulmonary,	3
Salpingitis,	1
Meningitis,	3
Pott's disease,	1
Polyserositis,	1
Cervical adenitis,	1
Renal tuberculosis,	2
	107

In the 335 cases checked and no tuberculosis found, 11 were hospitalized and the following conditions found:

1 pleural effusion
1 osteomyelitis
1 silicosis
2 lung abscesses
1 bronchiectasis
1 asthma
1 questionable tuberculosis of eye
2 reactors
1 died—autopsy report not received

Ages	
No. Cases	*Years*
3	1-12
10	13-19
17	20-29
22	30-39
17	40-49
16	50-59
12	60-69
7	70-79
3	80-
107	

* In about one-third of the families affected subsequent cases have developed.

Occupations

1 barber
1 blacksmith
3 carpenters
4 clerks
11 farmers
34 housewives and maids
2 nurses
20 mill workers and laborers
1 peddler
2 school teachers
5 school children
6 shoe factory workers
8 woodsmen
3 feebleminded
3 children under 6
2 not known
1 army

107

Towns where patients lived

2 Andover
3 Buckfield
2 Bethel
2 Canton
1 Denmark
4 Dixfield
3 Fryeburg
2 Hiram
1 Hebron
1 Lovell
13 Mexico
1 Milton Plantation
14 Norway
3 Oxford
2 Peru
1 Porter
8 Paris
1 Roxbury
29 Rumford
1 Stow
8 Sumner
4 Waterford
1 Woodstock

107

There is apparently nothing in these occupations or towns to indicate that they are conducive to tuberculosis. The conclusion is that wherever there is an open case, on an isolated farm, in a factory, school, logging camp, more tuberculosis will probably be found. However, the large number of deaths among housekeepers confirms the statement that tuberculosis is a house disease. Women in the home are more confined than men; they handle bedding, clothing, dishes; sweep and dust, all under cover. It is surprising how little sunshine they may get or even fresh air. "Shut that door!" is frequently a housekeeper's battle-cry. And today, in spite of all the health education, a child's reply to the teacher's question, "Do you sleep with your windows open?" may be, "No, my mother says it makes the house too cold!"

There are figures that show that tuberculosis has decreased in Oxford County. Ten years ago the Maine Public Health Association gave a tuberculin test in the Rumford and Mexico schools to 3,245 pupils and 321 X-rays were taken. Thirteen cases of childhood tuberculosis were found. In a recent school test in Mexico given by Dr. Arms, 830 tests were made and 49 X-rays taken. If the nine children already known were subtracted, the percent would be about 5, or less than half that of ten years ago discovered by the survey. One adult case was found (in adult, as in all these tests some adults are included) and twelve childhood cases or suspected childhood cases.

In 1942, Dr. Defoe and Dr. Elsemore tuberculin-tested about 100 pupils in the Dixfield schools without finding a single reactor. In each of the previous year's tests, 7 reactors were found.

Last year there were no deaths from tuberculosis in Rumford. This happened once before, 15 years ago, but then tuberculosis was not sought for as carefully.

Ten years ago there were 15 deaths in the county; last year, 5, a new low; this year, 9.

In the National Tuberculosis Bulletin of February, 1942, is an account of the one accredited county, with a death-rate of 5.5 per 100,000, which is less than the 10 deaths per 100,000 required for accreditation. This is in Lincoln County, Minnesota, and the first time the award has been given. The effort to win this distinction was part of a state-wide plan in an attempt to control tuberculosis. The certificate carries the signature of the Governor, the President of the State Medical Association, and the secretary

and executive of the State Board of Health. Lincoln is a rural county of 10,757 population with about half foreign born or of foreign parentage in which Danes, Germans, and Norwegians lead. It is in a sanatorium district, and for the past 20 years has had periodic clinics and, later, tuberculin testing in schools.

Oxford County, with a population of 42,671 (1940 census), is also in a sanatorium district and has had tuberculin testing in the schools, but there has been no plan developed on the part of the state or county to crusade for a lower death rate. The Oxford County tuberculosis work was the nearest approach to a county program. Although we are not an accredited county, the death rate has dropped from 37.5 per 100,000, ten years ago, to 16.4, the average of the past two years (1941-1942). In 1943, the death rate had dropped to 14.0 per 100,000.

Oxford, largely a rural county, is about one-third industrialized. Located here are the large paper mill in Rumford, shoe factories in Norway, woolen mill in Oxford, tannery in South Paris, match factory in Dixfield, and other wood-products industries. Rumford's population of 10,230 is more than 50% foreign born or of foreign extraction. Canadian-French lead, with Lithuanians, Italians, and smaller numbers of other nationalities peculiar to mill towns.

Of the 107 deaths, about one-third were in this foreign group.

Oxford County has 37 towns and plantations. In 23 of the rural communities there have been no deaths from tuberculosis for from 5 to 48 years. At least the larger part of the county could be accredited. It is in the industrial centers where most of the cases of tuberculosis are found. Hence the need of X-raying those employed in the industries. If this were done, and if the doctors like Dr. Bean would "slap a patch test on every patient who comes to the office" tuberculosis might sooner be added to the list of rare diseases, provided adequate rest treatment followed the diagnosis.

The latest "Provisional Report" of the National Tuberculosis Association on tuberculosis deaths (1942) gives these figures among others:

Porto Rico	244.4	per 100,000
Arizona	170.2	per 100,000
District of Columbia	75.1	per 100,000
Kentucky	62.6	per 100,000
Massachusetts	37.6	per 100,000
Maine	29.8	per 100,000
New Hampshire	23.2	per 100,000
Utah	11.9	per 100,000

In an article on tuberculosis appearing in the *Saturday Evening Post* (May 29, 1943) two counties are mentioned in which the death-rate varies from 114 per 100,000 to 13.2, and the question is asked, "Why this great discrepancy?" The different geographical positions are mentioned as though they might be a factor.

In Oxford County, the town of Sumner, with a population less than 600, had more tuberculosis deaths proportionately than any other town in the county. Why? Because there were a few families in which the disease was unchecked, five deaths occurring in one family. To me there is only one answer to the *Post* article: clean out the tuberculosis nests in the county with the high death-rate, and with intensive follow-up prevent further infection. Fifty years ago the death-rate in Oxford County was 177.3 per 100,000; today it is around 16.4.

Dr. Adams asked the question, "How many deaths in the state compared to the number of cases reported?" Dr. Mitchell has given these figures:

1940—269 tuberculosis deaths. 773 cases reported or 2.85 to each death.

1941—257 tuberculosis deaths. 682 cases reported or 2.45 to each death.

1942—236 tuberculosis deaths. 536 cases reported or 2.27 to each death.

Most of the tuberculosis cases are reported by the sanatorium or death certificate. Doctors, as a rule, do not report their cases of tuberculosis.

Today, the greatest case hunt of all time is on, namely, the examination by X-ray of all selectees. This is one great benefit of the war. That this is intended to be thorough is shown by the following cases:

A young man of Finnish parentage, the oldest of 13 children, was rejected after two deferments. Five X-rays were taken over a period of nine months. The recommendation is now made at Hebron that he be allowed to continue work but remain under medical observa-

tion. Supervision of him and the large family may prevent more cases of tuberculosis developing in a race in which its incidence is unusually high.

A man was sent to Hebron in 1936. At that time three brothers refused to be X-rayed. "All foolishness," they said. But the Selective Service Board this year found that two of them had tuberculosis and they were sent to the Western Maine Sanatorium. The third brother was told that he would be obliged to have an X-ray, but rather than submit to such high-handedness, he quit his job. Today, it isn't "The goblins 'll get you" but the implacable Selective Service Board.

The most productive "rejection" was a single man of 27 who worked in the woods. The address given was that of a sister with 9 children where he stayed week-ends, at least where he changed his clothes before going on the usual woodsman's relaxing and pocket-emptying spree. Finally contacted, his X-ray showed far-advanced tuberculosis. The sputum was positive. A routine check-up of the sister's family found a minimal case in a 14-year-old girl, a childhood type case with question of activity in a boy of 4 (his uncle's pet), and three others with questionable disease. All were reactors. It is worthy of note that this mother had previously refused to allow her children to be tuberculin-tested in school. While she bewailed the fact that Mary had been taken away, her oldest and her mainstay, she was reminded that Mary might still be at home if she had been picked up earlier in the school test.

Then there is the rejected selectee who, indignant that so healthy a man could neither work nor fight, was found not only to have a positive sputum but also to be the cause of four other cases in the family where he had lived "like a son" for two and half years.

The government is not only finding such cases of unsuspected tuberculosis and bringing into the open the uncoöperative suspect but also is equipped with X-ray apparatus and personnel to X-ray large numbers of industrial workers. In the Tuberculosis Institute held at the Massachusetts Institute of Technology last February the story of this service was told, a supposedly voluntary one, however—

An employee of a Connecticut war industry was X-rayed and rejected. "I was out in twenty minutes," he said. A second X-ray read at Hebron showed old tuberculosis with a question of activity, and he was advised to go there for study. I asked him about the "voluntary" X-ray and he said "no": they were obliged to be X-rayed.

And why shouldn't employers insist on having workers free from tuberculosis? Smallpox would not be tolerated nor leprosy, a disease less liable to cause infection than tuberculosis. The keynote sounded at the Tuberculosis Institute was to X-ray industrial workers. The idea is not new but, with the war forcibly opening our eyes to the great hazards and tremendous costs of tuberculosis and to the need of sound men in the service and out, the weeding out of the tuberculous employee is already being done, at least in war industries, and the protests of the die-hards is beginning to subside.

One tuberculosis hazard that I have not seen mentioned elsewhere is contagion from the promiscuous exchange of cigarettes. There has been a group of young people with tuberculosis, some with positive sputum (and in whose families no tuberculosis was found) who admit taking a "puff" and "passing it on." This has become a very common practice.

Following is the 10 years' cost, underestimated if anything, for sanatorium care of patients and their contacts in the Norway shoe factories and the Oxford paper mill, the county's largest industries:

Sanatorium cost for shoe factory cases:

18 persons in 13 families—$20,015 (1 patient is still in Hebron).

Sanatorium cost for Oxford Mill cases:

52 persons in 28 families—$56,360 (6 patients are still in Hebron).

These sums represent the mere cost of sanatorium treatment, most of which is borne by the state. The cost of aid to families and loss to industry would multiply these figures many times. There have been several families that have cost the state $10,000 and more per family.

Because of the great cost of care, at the Middlesex County Sanatorium in Massachusetts no patient is asked to pay for his X-ray,

Continued on page 80

The President's Page

"The American System"

There are certain groups in the country who wish to radically change the status of our profession, as well as our whole system of living. As I have before pointed out to you, this change would regiment us under a rigid system of government controls; it would curb our opportunities; arrest our progress and deprive us of our freedom; all this, mind you, under the plea of aiding the unfortunate and giving all people security. It would shackle our great profession as well as all medical science.

I reaffirm that the basic concepts of life as now exists under the present American system are fundamentally sound. Freedom of Enterprise is as necessary in our life as the four freedoms of the Atlantic Charter.

During this war, extraordinary controls have been surrendered to the Central Government, which, in my opinion, should be returned to the States upon its termination. I regard these principles as essential to the American system of life. To these principles, I believe that we should all dedicate ourselves unreservedly, and resolve to work and fight to preserve on the home front the cherished institutions of life, liberty and individual freedom so that our soldiers may return from the far-flung battle fronts of this global war, to find the institutions for which they fought unimpaired.

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Editorial

Bar Association Condemns Wagner-Murray-Dingell Bill

The Wagner-Murray-Dingell bill has been condemned by the House of Delegates of the American Bar Association as being replete with confusion in the form in which it is drawn. This proposal, say the lawyers, would inevitably produce communistic medicine in the United States and place the American people in a medical straitjacket. *The Journal of the American Medical Association* for March 11, in an editorial summarizing the bar association's report on the proposed legislation, says:

"The report criticizes the proposed legislation because it is 'prepared in a form which has become popular in the past ten years, being replete with involvement, cross references, new terminology, percentages and other confusing matters,' so that the chapter on socialized medicine leaves the reader in utter confusion as to its meaning. The distinguished lawyers who prepared this statement point out that 'no one can estimate how much tax money is involved or how many people are covered' from the face of the bill. Since, however, the bill would propose to include every individual worker and since every family in the United States has at least one and one-half employed working members, the coverage would include practically every family in the United States.

"The statements made by Senator Wagner in introducing this measure are analyzed and at least twelve are pilloried as incorrect and misleading.

"A fourth section of the report emphasizes the high quality of medical service prevailing in the United States today and points out that the indigent who are most in need of medical care would not be covered by this measure. 'The Wagner-Murray-Dingell bill,' says this statement, 'would inevitably produce communistic medicine in the United States and would put all the people in a medical straitjacket under the supervision of the federal government for an alleged service which the vast majority either do not require or are able to provide for themselves.'

"Finally, the report emphasizes that there are being developed in this country and under our system of private enterprise many plans for providing adequate medical care without paying the price of socialized medicine. At a previous session the House of Delegates of the American Bar Association stated its opposition 'to any legislation, decree or mandate that subjects the practice of medicine to federal control and regulation beyond that presently imposed under the American system of free enterprise.'

"As a reason for its entrance into consideration of the Wagner-Murray-Dingell bill, the House of Delegates of the American Bar Association explains that its organization is limited to an expression of opinion and judgment with respect to those fields which relate to the administration of justice and which directly affect the safeguards and protection of the rights and liberties of the citizens of this country. When, therefore, under the pretext of the general welfare, legislation is proposed in Congress which either inadvertently or with deliberate subtlety constitutes a direct attack on the rights and liberties of the citizens of this country, it becomes the duty of the American Bar Association actively to voice its objections. The six objections listed specifically include the extent to which the measure depreciates local self government: a condemnation of the authority vested in the Surgeon General of the United States Public Health Service by S. 1161 which would give him the power arbitrarily to make rules and regulations having the force and effect of law; a condemnation of the procedure by which physicians, hospitals and individual citizens would be made to serve the purposes of a federal agency; the failure of the bill to safeguard the rights of patients, citizens, hospitals, or doctors, which might be denied by the arbitrary or capricious action of one man; the failure of the bill to provide for any appeal from the action of the Surgeon General; and, finally, the severe condemnation of the vicious system whereby administration officials judge without court review the actions of their subordinates in carrying out orders which might be issued to them.

"The final paragraph of this report of the American Bar Association merits quotation and requotation as a fundamental appeal to the citizens of the United States to protect the Constitution. This statement says:

"The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear upon them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates."

The Ninety-first Annual Session

The ninety-first annual session of the Maine Medical Association will be held at the Sam O set Hotel, Rockland, June 25, 26 and 27, this year. The Sam O set Hotel is one of Maine's most beautiful and will afford you comfort and rest. There is a fine golf course and swimming pool. A delightful spot in which to spend three days.

The program for the session is about completed. Doctor Fishbein will start the meeting as he has assured me that he will be present on Sunday evening, June 25, to speak on some subject which will be of interest to us. The Surgeon Generals of the Army and Navy have designated an outstanding speaker to tell us some of their war-time experiences and treatment of the sick and wounded. Doctor Parran, Surgeon General of the U. S. Public Health Service has generously consented to attend and will speak during the afternoon of June 27. The Chairmen of the various Conferences are very coöperative in getting their material together. A more detailed account of the program will be given in the next issue of the JOURNAL.

War has made many changes in our way of living. Let us all hold fast to our fine Maine Medical Association. The way to make this meeting a success is for all the members to attend.

ROLAND L. MCKAY, M. D.,
Chairman, Scientific Committee.

Correspondence

Use of Gasoline to Attend Annual Meeting

OFFICE OF PRICE ADMINISTRATION

PRESCOTT H. VOSE
State Director

Maine State Office
151 Water Street
Augusta, Maine

Office of
State Director

Frederick R. Carter, M. D.
Secretary-Treasurer, Maine Medical Association
142 High Street, Portland 3, Maine

March 13, 1944

Dear Dr. Carter:

If your doctors participate in the ride-sharing plan by filling their automobiles in going to Rockland, it is permissible to apply for and use gasoline for the purpose of attending a meeting of the Maine Medical Association at the Sam O set Hotel.

In such cases where ride-sharing cannot be accomplished, alternate means of transportation, such as the railroad or buses, must be taken in all cases possible.

Only when the above two provisions fail to take care of transportation to the meeting can a doctor properly apply for and use gasoline to go by himself.

You should not regard these rules as technical; on the contrary, they are made necessary, and I am sure you will agree, because of the very critical gasoline supply situation that faces the east coast today.

Sincerely yours,

PRESCOTT H. VOSE,
State Director.

PHV:T

Major N. H. Nickerson, Greenville, Decorated in Tunisia, Describes Ceremony

Major N. H. Nickerson of Greenville was one of three to be given citations for outstanding medical and liaison work in behalf of French and Arab civilians at Bizerte, Tunisia, recently. The other two receiving citations were Lt. Col. J. F. Simon, Ada, Oklahoma, and Capt. W. R. Simone, St. Petersburg, Florida. These three were presented with high military awards in formal ceremonies, an account of which is given below in an article taken from the "Stars and Stripes," a publication of overseas servicemen.

Doctor Nickerson was graduated from the University of Maine, Bowdoin Medical School in 1919, interned one year at the Eastern Maine General Hospital, Bangor, then settled in Greenville, and practiced there until he enlisted in the U. S. Army Medical Corps in the fall of 1942. After six months' preliminary training in the United States, he was sent overseas and stationed at Bizerte.

Doctor Nickerson for a long period was president of the Piscataquis County Medical Society, served as its Secretary for several years, and when he enlisted was Councilor for the fifth district of the Maine Medical Association. He is widely known throughout the State. Not only is he an outstandingly efficient doctor, but he lends splendid coöperation to his fellow physicians and is familiarly known by them as "Nick."

The article in "Stars and Stripes" reads in part:

"For outstanding medical and liaison work in behalf of French and Arab civilians, Lt. Col. J. F. Simon, Ada, Okla.; Maj. N. H. Nickerson, Greenville, Me.; and Capt. W. R. Simone, St. Petersburg, Fla.; were presented with high French military awards in formal ceremonies."

The French Medal of Commander of the Nishan was presented to Lt. Col. Simon for his establishment last fall of a clinic for indigent Arabs and French in the war-torn city, and to Major Nickerson for assistance in operation of the clinic. Capt. Simone was awarded the Medal of Officer of the Nishan for exemplary liaison work. "The officers were given citations engraved in French and Arabic, by Adneau Massoneau, French civil controller. J. Bayena, director of cabinets in the Tunisian government, represented the resident general; and Ben Hassen Daoub, Caid, was present at the ceremonies in behalf of the Arab population. The commanding officer of the eastern base section and other high ranking American officers were also in attendance."

In a letter sent to fellow physicians in Piscataquis County, which follows in part, Doctor Nickerson describes the ceremonies in more detail:

"The presentation of the medal took place in a hall a short distance in another town. They had a band, admittance was by invitation only. In the hall a good-sized bar dispensed free drinks to all.

"The presentation was made in French, then translated into English. The band played the Tunisian, French, English and United States national anthems. We were embraced and kissed on each cheek by various French officials and a hand shake from United States and British. The big event of the day for me was the dinner. I stole a menu for a souvenir."

The menu: "*La Maa Kouda.* This was a bluish white slice of bread with hard-boiled whole eggs in it. Sauce on it. It was good. *Les brikes a la Cervelle.* Brikes have been served at every Arab dinner I have eaten. They are a soft-cooked egg in pastry. They are three cornered. It is a considerable trick to eat them without getting covered by egg. One must bite a corner off while sucking it. He must suck every time he bites it. They usually are too highly spiced with green peppers to appeal to my taste, too hot. *La Couscous.* This is made from wheat. It likewise is served at every Arab meal. It can have fish, chicken or meat in it. It is usually too hot, too many green peppers. That served at the celebration, however, was flavored for European or United States taste. It was not too hot. *Langue deveau sur causpe,* this was tongue. *Poulet au petit pois,* chicken. *Khoublet ellouze,* this was mild cheese. *Les cakes a la creme,* almond cream cake. This was excellent. *La yebna,* a kind of doughnut with cocoanut and dates. Coffee and small cookies. Brandy or liquor.

"The plates were changed after each course. Men waited on the table. They wore white turbans on the head rather than the usual red fez. I never saw so many knives, forks and spoons at each place as were at that table. In front of each place were four glasses. The glasses were kept full all the time; mineral water, vin rouge, vin blanche, champagne. There were flowers at each place also. The room was highly perfumed.

"There were twelve at dinner. Lt. Col. Simon, Capt. Simone and myself, a British admiral, a French admiral. Much of the conversation was in French. I kept still.

"Most of the medical department has been changed. I now am the only M. D. in the post who was here a year ago. We are having plenty of rain here now, every day for ten days, I think."

Necrologies

George Francis Bates, M. D., 1860-1944

George Francis Bates, M. D., 84, practicing physician in Yarmouth, Maine, for thirty-three years before he retired in 1938, died suddenly on Monday, March 6, 1944, at a Portland hospital.

He was born in Yarmouth, January 17, 1860, son of James M. Bates, M. D., and Hester Sawtelle Bates. He was graduated from Yarmouth High School, Bowdoin College, and received his medical degree from the Long Island College of Medicine in 1885. He served his internship at the Long Island College Hospital and began his practice at Minneapolis, Minnesota, later going to Hillsboro, North Dakota. He returned to Yarmouth in 1905, and was in continuous practice there until he retired after more than half a century in the service of his profession, and moved to Portland.

Doctor Bates was a member of the Cumberland County Medical Association, the Maine Medical Association, and the American Medical Association. He was presented with the Maine Medical Association's gold medal in recognition of fifty years in the practice of medicine at the June, 1935, annual meeting of the Association. He was also a member of Casco Lodge, A. F. & M.; Cumberland Chapter, R. A. C., of which he was a past high priest in Yarmouth; Portland Council and St. Alban Commandery, Knights Templar.

He is survived by his son, Edward C. Bates, of Portland.

Silas Oliver Clason, M. D., 1879-1944

Silas Oliver Clason, M. D., 65, a practicing physician in Gardiner, Maine, for the past thirty-eight years, died suddenly Thursday, March 2, 1944, at his home on Dresden Avenue.

He was born at Gardiner, November 4, 1879, the son of Pell R. and Eliza B. Douglas Clason. Doctor Clason was graduated from Bates College in 1900, from Bowdoin Medical School in 1904, and interned at St. Joseph's Hospital in Providence, R. I. He began his practice in Gardiner in 1906 and remained there to the time of his death.

He was on the staff of the Gardiner General Hospital, and was a member of the Kennebec County Medical Association, the Maine Medical Association, and the American Medical Association. He attended the Methodist Church in Gardiner, was a member of the Masonic Lodge, and an incorporator of the Gardiner Savings Institution.

He is survived by his widow.

Charles Henry Hunt, M. D., 1881-1944

Charles Henry Hunt, M. D., 63, a practicing physician in Portland, Maine, for more than forty years, died suddenly Thursday, January 27, 1944, at his home on Winter Street.

A life-long resident of Portland, he was born January 9, 1881, son of the late Doctor Charles O. Hunt, for many years superintendent of the Maine General Hospital, and Cornelia Cotton Hunt. He was graduated from Portland High School, Bowdoin College in 1902, and Bowdoin Medical School in 1905. He served his internship at the Maine General Hospital.

Doctor Hunt was a member of the Cumberland County Medical Association, the Maine Medical Association, the American Medical Association and the Portland Medical Club. He attended the First Parish Church. He had been chairman of the Civilian Defense Medical Unit since its inception two years ago.

He is survived by his widow, Mrs. Ella Wheeler Hunt; a daughter, Mrs. Wadsworth L. Hinds of Waterville; a sister and two grandsons.

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Francois J. Faucher, M. D., Grand Isle
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, Edward Thegen, M. D., Bucksport

Kennebec
President, Clarence R. McLaughlin, M. D., Gardiner
Secretary, Clair S. Bauman, M. D., Waterville

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Penobscot
President, Manning C. Moulton, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

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President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

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Secretary, Maurice E. Lord, M.D., Skowhegan

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York
President, Waldron L. Morse, M. D., Springvale
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

100% Paid Membership for 1944

Piscataquis County Medical Society
Somerset County Medical Society
Aroostook County Medical Society
Penobscot County Medical Society
Waldo County Medical Society

Androscoggin

The regular monthly meeting of the Androscoggin County Medical Association was held Thursday, February 17, 1944, at the auditorium of the Central Maine General Hospital, Lewiston. Dr. D. F. D. Russell presided. One application for membership was read. There were twelve members present.

Dr. Morris Goldman, of Lewiston, presented a paper entitled *New Treatments of Fractures.* Doctor Goldman recently completed a six-months' course at the Boston City Hospital. He mentioned some of the newer approaches in the treatment of fractures of the hip, including the Smith-Peterson nail for intracapsular fractures, the Smith-Peterson nail and plate combinations, the Blount blade, Roger Anderson method, and the well-leg traction treatment of intratrochanteric fractures.

The beaded wire with a Pease bow for spiral fractures was also discussed as well as the McMurray osteotomy for ununited fractures of the neck of the femur, by use of the Blount blade. Mention was made of the open reduction of fractures, particularly the fixation of difficult angle fractures. X-rays plates were shown illustrating many of these procedures.

Leroy C. Gross, M. D.,
Secretary.

Cumberland

The Cumberland County Medical Association met at the Eastland Hotel, Portland, on March 3, 1944. The principal item on the business calendar was the election of officers.

The following panel was elected:

President, Dr. Albert W. Moulton, Portland.

Vice-President, Dr. Henry P. Johnson, Portland.

Secretary-Treasurer, Dr. Joseph E. Porter, Portland.

Councilors (to continue): Dr. George A. Tibbetts, Dr. Luther A. Brown, Dr. George O. Cummings.

Delegates to the 1944 annual meeting of the Maine Medical Association:

For One Year: Dr. C. Earl Richardson, Brunswick; Dr. Richard S. Hawkes, Portland; Dr. William Holt, Portland; Dr. Benjamin Zolov, Portland.

For Two Years: Dr. Oscar R. Johnson, Portland; Dr. Joseph E. Porter, Portland; Dr. Louis L. Hills, Westbrook.

Alternates for One Year: Dr. Isaac M. Webber, Portland; Dr. Harlan R. Whitney, Portland.

For Two Years: Dr. Theodore C. Bramhall, Portland; Dr. Harold V. Bickmore, Portland.

Committee on Public Relations: Dr. Mortimer Warren, Dr. Adam P. Leighton.

Legislative Committee: Dr. Franklin A. Ferguson, Dr. Edwin W. Gehring.

The society passed a resolution to the effect that the indiscriminate use of the sulfa drugs is attended with

"Are the trout still biting in Seward's Creek? Is the rowboat caulked? Are the strawberries up?"

These are the things he thinks about. For these are the "little things" that to a soldier, as to all of us, add up to "Home."

It happens that to many of us these important little things include the right to enjoy a refreshing glass of beer. How good it is . . . as a beverage of moderation after a hard day's work . . . with good friends . . . with a home-cooked meal.

Men of the Marine Corps say letters keep up morale... Write that V-Mail letter today.

A glass of beer or ale—not of crucial importance, surely . . . yet it is little things like this that help mean home to all of us, that do so much to build morale—ours and his.

Morale is a lot of little things

(As you, Doctor, know better than most)

BREWING INDUSTRY FOUNDATION

a certain degree of danger, and therefore recommended that prescriptions be marked "Not refillable."

The speaker of the evening was Dr. William T. Green of the Children's Hospital, Boston, whose topic was *Painful Feet.* The author described the evolution of the foot, and the various malformations commonly encountered during its development. Various corrective measures were presented and well-illustrated by a number of lantern slides.

JOSEPH E. PORTER, M. D.,
Secretary.

Penobscot

The Penobscot County Medical Association met on Tuesday, February 15, 1944, at Bangor, in conjunction with the Medical Personnel of the Armed Forces, in that district, under the Post-Graduate War Training Program.

Dr. Burton W. Hamilton and Dr. Louis Wolff, both of Boston, were guest speakers.

In the afternoon a clinic was held at the Eastern Maine General Hospital at which various types of heart cases met with at the Induction Center were discussed.

Doctor Hamilton spoke on *The Heart in Young Adults,* and Doctor Wolff discussed *Syncope,* at the evening meeting which followed a dinner at the Bangor House.

FORREST B. AMES, M. D.,
Secretary.

Somerset

The annual meeting of the Somerset County Medical Society was held on September 21, 1943, at Skowhegan. There were nine members present.

After due discussion the Farm Security Plan was rejected by a vote of 8-1.

A Nominating Committee was appointed by the Chair and the following slate of officers presented, and elected:

President, Dr. Lester F. Norris, Madison.

Vice-President, Dr. Harvey F. Doe, Fairfield.

Secretary-Treasurer, Dr. Maurice E. Lord, Skowhegan.

Censors: Dr. H. E. Marston, Dr. W. H. Walters, Dr. W. S. Milliken.

Delegate to the 1944 annual meeting of the Maine Medical Association: Dr. Walter S. Stinchfield, Skowhegan. Alternate, Dr. Maurice S. Philbrick, Skowhegan.

A program of various fractures was presented and discussed.

MAURICE E. LORD, M. D.,
Secretary.

Have You Paid Your 1944

State and County Dues

Notices

Civilian Medical Examiners to Receive Service Awards

Civilian Medical Examiners at Army Induction Centers are eligible for the Service Awards presented to civilian employees of the War Department according to a letter from John W. Martyn, Administrative Assistant, War Department, to Senator Owen Brewster, copy of which was forwarded to George Goldberg, D. M. D., of Portland, Maine.

S. Judd Beach, M. D., Portland, Secretary-Treasurer American Board of Ophthalmology

S. Judd Beach, M. D., has been elected Secretary-Treasurer of the American Board of Ophthalmology, and all future communications should be addressed to him at 704 Congress Street, Portland 3, Maine.

Second "War Conference" on Industrial Medicine, Hygiene and Nursing St. Louis, May 8-14, 1944

The Second "War Conference" of industrial physicians, industrial hygienists and industrial nurses will be held in St. Louis, Missouri, May 8-14, 1944, at the Hotel Jefferson. The participating organizations are: (1) American Association of Industrial Physicians and Surgeons, (2) American Industrial Hygiene Association, (3) National Conference of Governmental Industrial Hygienists, and (4) American Association of Industrial Nurses; and theirs will be a week-long program of joint and separate meetings.

War Food Administration

Cream for the Sick

Mr. Charles M. Quinn, State Supervisor, War Food Administration, has requested that the article entitled, "The Prescription of Cream for the Sick" which appears in *The Journal of the American Medical Association,* February 19, 1944, page 511, be brought to the attention of the members of the Maine Medical Association. If you do not have this issue of the *Journal* reprints of the article may be obtained by writing to Mr. Quinn at the Office of Distribution, Post Office Building, Hallowell, Maine.

Book Review

"Gynecology"

By: Lawrence R. Wharton, Ph. B., M. D., Associate in Gynecology, The Johns Hopkins Medical School; Assistant Attending Gynecologist, The Johns Hopkins Hospital; Consultant in Gynecology, The Union Memorial Hospital, Hospital for Women of Maryland, Sinai Hospital and Church Home and Infirmary.

Published by W. B. Saunders Company, Philadelphia and London, 1943. Price $10.00.

The author in writing this book has noted the fact that there have been many changes in the practice of gynecology in recent years, a large part is now medical and preventive. It describes, also, the accepted surgical and operative procedures as well as the medical treatment. This book should appeal to the specialist and general practitioner as well as to the student of gynecology.

Progress in the Crusade Against Tuberculosis in Oxford County—Continued from page 71

and the county assumes the expense. Today I am arranging for a free X-ray of the man discharged from the Connecticut industry. I know that, asked to pay for it, he "wouldn't bother." He has gained 12 pounds and "feels fine!"

Over forty years ago in Maine, a far-seeing group of doctors and others formed the first state organization to combat tuberculosis, "The Maine State Sanatorium, Inc." The Maine Public Health Association followed this. To such pioneers, to the organizations and forces already in operation, and to the coöperation of many people, the success of this work is due. Dr. Wakefield's offer to read X-rays at the beginning and his practical suggestions; subsequent X-ray readings and recommendations by Dr. Adams and his associates at Hebron; Dr. Brewer's brief but friendly coöperation at Hebron; the responsiveness of the doctors at Augusta when adjustments were needed for sanatorium care; Dr. McCarty always ready to help even with major surgery because of his appreciation for what Mr. Bingham has done for the hospital; other doctors who have shown the same spirit; Dr. Atwood who tuberculin-tested the school children of another town, a 100% job, because of an active case found, and who wrote, "To render a humanitarian service was a pleasure;" School Superintendent Redding who got them together in the summer; Dr. Davis, hospital intern at the time, who tuberculin-tested pupils of another rural school because the teacher, "home with the flu," was found to have tuberculosis and positive sputum; Dr. Arms who travels to remote places to test one or several individuals when otherwise the examination might not be accomplished; Mr. Jones, Rumford Hospital technician, a willing and tireless helper, whose coöperation Miss Snyder is continuing; welfare agencies, social workers, nurses, especially Miss Dow in the Oxford Mill, and other individuals who have contributed money, clothing, milk, and other aid. As a result of this combined effort, the death rate from tuberculosis in Oxford County has been reduced more than 50% in the past ten years.

In summing up this ten years' work, it would seem that enough has been accomplished to make worthwhile the lengthened experiment made possible by Mr. Bingham and the Bingham Associates.

July 12, 1943.

The Journal
of the
Maine Medical Association

Volume Thirty-five Portland, Maine, May, 1944 No. 5

A Tabulated Report of 8 Bacterial Endocarditis Cases

Charles W. Steele, M. D., F. A. C. P., Julius Gottlieb, M. D., F. A. C. P.,
Central Maine General Hospital, Lewiston, Maine

INTRODUCTION

The new chemotherapeutic drugs have given rise to a renewed hope that bacterial endocarditis may more often be cured. That treatment with sulfanilamide and its derivatives has not been entirely a failure is attested to by the thirty-one cured cases Heyer and Hick[1] found reported in the literature from 1935 to 1941. Furthermore, they were able to add to this group of cures, two cases of their own out of a total of fifteen treated with sulfanilamide, sulfathiazole and sulfapyridine.

It would seem very necessary that every physician report all cases of bacterial endocarditis treated with chemotherapeutics, in order that a sufficient number of cases be available to permit selection of the most efficacious chemotherapeutic agents in each bacterial type of endocarditis.

The following eight cases of proven bacterial endocarditis came to post mortem, either at the Central Maine General Hospital or at some one of the various Bingham Associated hospitals here in Maine during the past eighteen months. A brief summary of the important clinical and pathological data for each of the eight cases has been recorded in Table I; while the kind and amount of drug administered, the laboratory data, etc., has been shown graphically on the individual charts that follow. The records on Case No. 1 (W. L.), and Case No. 6 (J. H.), were of particular interest and will be presented in detail.

Clinical Summary

Patient: W. L.

This 45-year-old white male entered the hospital December 2, 1940, and died April 3, 1941.

Chief Complaint

Non-productive cough, night sweats, loss of weight and appetite and abdominal discomfort.

Present Illness

Began two years ago with a non-productive cough and was followed a year ago by severe drenching night sweats. Three months ago, there was a loss of 25 pounds of weight in three weeks. Abdominal discomfort most marked in the epigastrium and accompanied by loss of appetite and gas but not by nausea and vomiting, began about 3 weeks before entry. His regular bowel habit changed to constipation alternating with diarrhea. There was no melena but stools were small in calibre.

TABLE 1.

CASE NO.	AGE SEX	PAST ILLNESS	PRESENT ILLNESS	PHYSICAL FINDINGS
W. L.	45	4 attacks of rheumatic fever (age 9-14) Pneumonia (age 13-18)	Cough, night sweats (2 yrs.) Weight loss, anorexia (3 mos.) Abdominal discomfort, nausea and constipation (3 wks.)	Malor flush, cyanosis, dyspnea, orth weakness, cardiac enlargement, systolic and diastolic murmurs, megaly, fever, profuse night swea
E. J.	26	Sinus trouble ? Salpingitis	Onset abrupt 4 days previous with chills, fever 104°, headache, nausea, diarrhea, upper abdominal tenderness and severe prostration	T. 104°, P. 120, R. 40 Acutely ill, prostrated LLQ abdominal tenderness Tenderness and fullness in left vau Absent reflexes Petechial spots
E. F.	3	Cough and cold 3 months previous No history of rheumatic fever	Bleeding from gums Swelling at angle right jaw Anorexia, weight loss, fever Abdominal pain, irritability	Hematoma of upper eyelids Anemia, dehydration Adenopathy of preauricular, axillar maxillary nodes Systolic heart murmur Hepatomegaly
J. B.	51	Diphtheria (childhood) Pneumonia (6 yrs. ago) No history of rheumatic fever	Nausea, weakness, diarrhea, pain in legs Weight loss of 1 mo.'s duration	T. 99°, P. 70, R. 20 Chronically ill, dehydrated Recent weight loss, carious teeth, tongue Pharynx injected Tenderness RUQ Dullness and broncho - vesicular sounds rt. apex
A. F.	37	Chicken pox, measles Rheumatic fever (age 7-9) Pneumonia (age 25-27)	Two weeks before entry to hospital was treated for pneumonia with sulfathiazole. TPR returned to normal. Phys. signs cleared. Pt. allowed up on 12th day. T. rose to 102°, in general felt mean and had pain in finger tips, toes, knee joints. Returned to hospital	T. 101.6°, P. 104, R. 24 Ashen hue to face Systolic apical heart murmur Tender finger tips and toes Signs consistent with resolving pneu posteriorly in left lung Shaking chills
J. H.	72	Chronic cholelithiasis Moderate elevation of systolic blood pressure ? Mild coronary disease	Began 9 days before entry with grippe, cold and headache. 4 days after, had shaking chills, fever, nausea. Finally, during chill, developed sudden headache, mental confusion, delirium	P. E. essentially negative until en hospital Then, T. 104.8°, P. 105, R. 31 Stiff neck, semi-comatose Loud systolic murmur over precor B. P. 160/80 Absent reflexes Skin clear
M. P.	45	Pneumonia (age 1 yr.) Measles (childhood) ? appendicitis (age 43) ? Undulent fever at onset of P. I. 6 wks. ago	High temperature, 104° Weakness, weight loss Sulfanilamide administered for ten days before hospital entry Blood cultures taken and showed strep. viridans	T. 100.6°, P. 88, R. 20 Harsh systolic apical murmur Aortic systolic murmur No petechiae Sulfanilamide level 14 mgs %
G. G.	23	All common childhood diseases except scarlet fever Caesarean section (age 21), no complications No history rheumatic fever	8 wks. before entry, developed generalized joint pains, malaise, chills, fever; increased weakness, afternoon flushing, mild chills continued. A hacking, nonproductive cough began 3 weeks before and persisted until her hospital entry	Pale, acutely ill Heart rate rapid, 100 to 130 Respirations 40 Loud apical systolic murmur, card largement Moderate abdominal distension Heptomegaly and edema of lower le ankles

COMPLICATIONS COURSE IN HOSPITAL	DIAGNOSES CONSIDERED (* Final Clinical Diagnosis)	BACTERIA RECOVERED	Treatment Summary and Course, Chart No.	PATHOLOGY (See photos)
ever ash congestive failure abdominal discomfort death	Undulent fever Tuberculosis *Rheumatic heart disease with mitral stenosis *Bacterial endocarditis	Staphylococcus albus	IA IB	Healed mitral vegetative endocarditis; Staphylococcus albus Rheumatic heart disease with mitral stenosis and valve obstruction Adhesive pericarditis Splenomegaly Nutmeg liver Healed renal infarcts
y and retraction of neck e Kernig and Babinski s of petechiae into coma and died	*Salpingitis *Septicemia *Meningitis *Endocarditis	Staphylococcus	2	Acute staphylococcus endocarditis, mitral valve Cerebral, cardiac, splenic, renal infarcts Meningitis Septicemia
idation at rt. apex °, P. 120, R. 60 odules on abdomen and arms after 27 days, due to peripheral circulatory failure	Aplastic anemia *Leukemia *Septicemia Pneumonia	Hemolytic staphylococcus	3	Acute staphylococcus aureus vegetative endocarditis, mitral valve Multiple infarcts of kidneys, spleen brain, skin Subperiosteal abscess—skull Bronchopneumonia
temperature emia, anemia precordial pain requiring morphine uria, albuminuria chill, coma in 26 days	*Bacteremia *Anemia *Nephritis Pneumonia	Gram positive diplococcus Bile Sol.	4	Pneumococcus mitral endocarditis Rheumatic heart disease Renal, splenic, hepatic infarcts Splenic artery, septic thrombosis Mitral stenosis
lar sustained temperature ches sis of lips, fingers and toes ed chills emia nd decreased resonance over base-lung ce, Cheyne-Stokes resp. le petechial hemorrhages n collapse	*Acute bacterial endocarditis due to pneumococcus type III *Resolving pneumonia *Cerebral emboli *Pulmonary emboli	Pneumococcus Type VII	5	Ulcerative pneumococcic endocarditis, mitral valve Rheumatic heart disease Mitral stenosis Renal, splenic infarcts Pneumococcic septicemia Cerebral emboli
f use and discoloration of left leg legia, rt. arm and leg lty in swallowing spinal fluid emia ved and regained consciousness and of extremities ed and died after 10 days in hospital	*Meningitis *Bacteremia *Pneumococcus endocarditis Multiple emboli with brain, lung, splenic, kidney infarcts	Pneumococcus Type XVI		Vegetative endocarditis, type XVI pneumococcus, mitral ulceration Tricuspid vegetation, modified ? healing Minimal pneumococcus type XVI meningitis Splenic and cardiac infarcts Cerebral infarcts Subdural hemorrhages ? of heparin etiology
type temperature ls followed by temp. rise to 105° n left hypogastric region on two occasions se sweating l confusion around heart 2 days before exodus 34th hospital day	Undulent fever *Subacute bacterial endocarditis *Splenic infarcts *Secondary anemia	Streptococcus viridans	7	Subacute vegetative endocarditis of aortic valve, streptococcus viridans Rheumatic mitral and aortic valves with insufficiency Old and recent infarcts of spleen and kidneys Nutmeg liver
ted chills type temperature, 98 to 105° rose to 103 in chest and arms and fingertips sis, nausea and vomiting turia, pyuria, albuminia 23 days after hospital entry of cardiac failure	Influenza *Anemia, hyperchronic *Uremia Nephritis *Bacterial endocarditis Cardiac hypertrophy, pericarditis Cardiac decompensation Congenital heart disease Septicemia Perinephritic abscess	Blood cultures taken 2/6/41 and 2/9/41 were negative	8	Subacute bacterial endocarditis, streptococcus Vegetation of mitral valve with ulceration Myocardial and splenic infarcts Rheumatic heart disease Moderate coronary sclerosis

Past History

Revealed four attacks of rheumatic fever between the ages of 9 and 14 years and pneumonia at the age of 13 and 18 years.

Physical Examination

Revealed a well-developed male with a malor flush, slight cyanosis, some orthopnea and appearance of recent weight loss. Other positive findings included: temperature of 100, barrel-shaped chest, heart enlarged markedly to the left with apex impulse seen and felt well out in the anterior axillary line about 13 cm. to the left of the mid-sternal line, a low mid-diastolic and a rumbling presystolic and systolic apical murmur, not associated with a palpable thrill, a tender liver enlarged 4 fingers below the costal margin and slight clubbing of the fingers. The heart rate was 80, the rhythm regular, lungs were clear, and there was no peripheral edema.

Laboratory Data

Seven urinalyses between December 2, 1940, and March 11, 1941, were essentially negative.

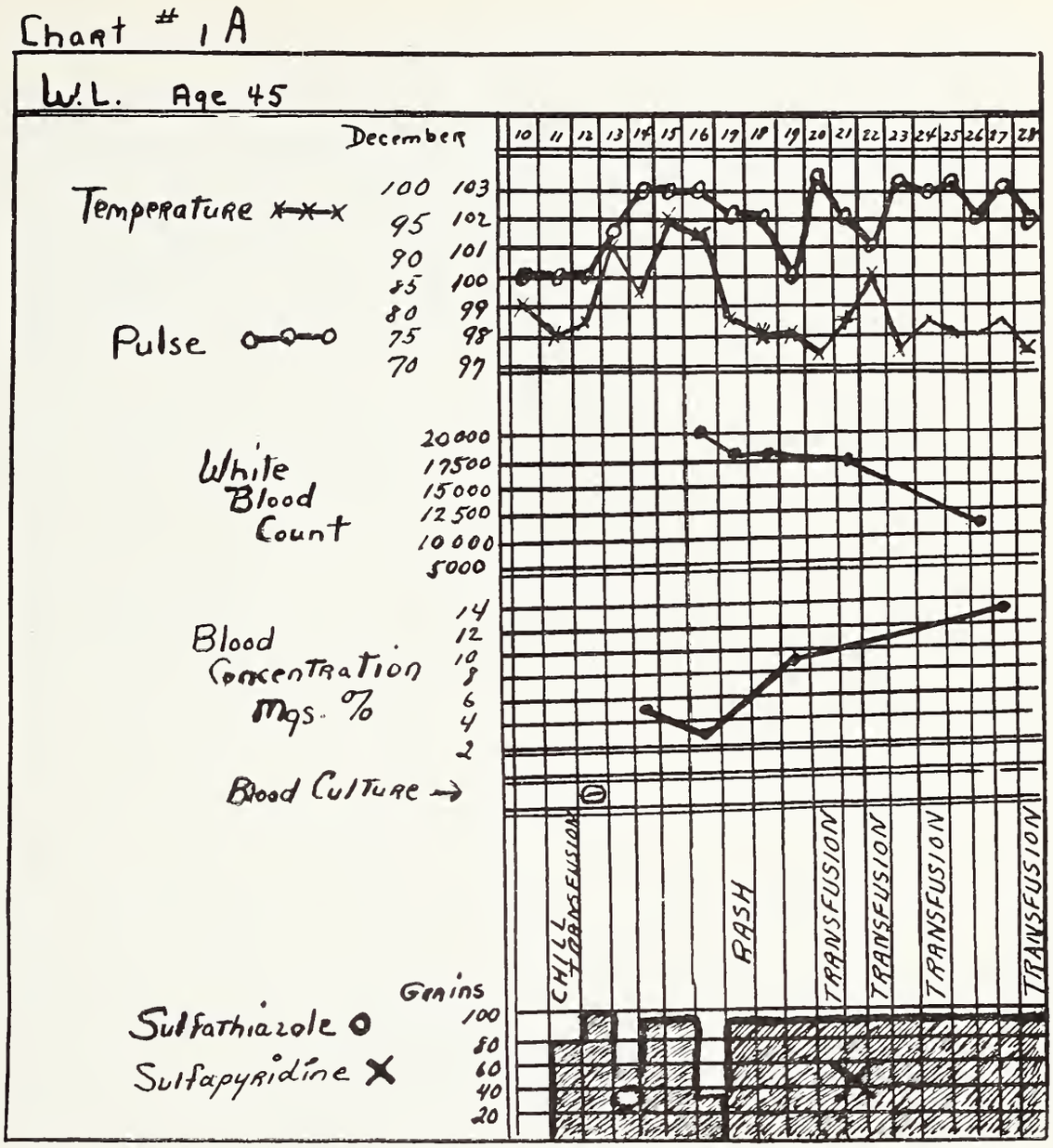
Course

This patient at his first hospital entry in December, 1940, ran a fairly high temperature which averaged 102° to 103°; and in view of his history of rheumatic fever and the physical findings consistent with rheumatic heart disease, bacterial endocarditis was suspected and blood cultures were taken, one of which showed non-hemolytic staphylococcus albus. He had a severe chill on December 11, 1940; consequently sulfathiazole was started and continued for six days without producing any fall in the temperature (See Chart No. 1A). A rash then appeared and sulfathiazole was omitted. Sulfapyridine therapy was begun on December 17, 1940, and was continued for a period of 12 days (See Chart No. 1A).

The patient's temperature had returned to normal but he continued to perspire profusely at night. During the early part of January he was allowed up, but by January 18, 1941, he developed signs of congestive heart failure and had to be digitalized, following which the congestive failure and edema improved. The temperature began to go up again on January 18th and by January 20th had reached 104°. Sulfathiazole therapy was resumed at 6 P. M. on January 20th but the patient soon developed urticaria and a rash and the drug was omitted at noon on January 23rd and Sulfapyridine was started at 8 P. M. on the same day and was given over a period of eight days (See Chart No. 1B). On January 25th, the temperature had come down to 99° in the A. M. and 100° in the P. M. but it began to climb again the following day and ranged between 98° in the A. M. and 102° in the P. M. for the following eleven days. The patient complained of pain and tenderness in the splenic area on January 28th. It was felt that the steadily rising temperature might indicate drug fever and Sulfapyridine was discontinued on January 30th. Another single dose attempt to administer this drug on February 11th and again on February 13th produced severe urticaria, mental confusion and excitement, chills and fever of 102°.

Blood Examinations

Date	*HGB*	*RBC*	*WBC*	*Polys*	*Lymphs*	*Monos*
December 2, 1940	76	3,890,000	10,000	64	28	8
December 3, 1940			13,000	74	22	4
December 16, 1940	90	5,200,000	20,000	63	35	2
December 18, 1940	90	5,080,000	18,000	84	12	4
December 21, 1940			18,500	83	16	1
December 26, 1940	87	3,600,000	12,300	78	17	3
January 13, 1941	80	3,810,000	10,150			
January 27, 1941	80	3,980,000	9,500			
February 27, 1941	90	4,770,000	15,300	77	20	3
March 10, 1941	90	4,235,000	18,500	93	1	6
March 12, 1941	95	4,730,000	15,700	90	6	3



Blood Culture: December 9, 1940—positive for non-hemolytic staphylococcus albus. Cultures taken on the following dates all negative: December 7, 1940; December 10, 1940; December 12, 1940; January 20, 1941; March 29, 1941; April 1, 1941.

Sedimentation rate: December 9, 1940, was 25 in one hour; January 6, 1941, was 26 in one hour.

Kahn, Widal and agglutination tests for Br. abortus were negative.

Blood chlorides 526 mgs % on December 18, 1940.

Sputum negative for tuberculosis.

Stool was only slightly positive for occult blood.

X-rays

Showed heart enlarged in transverse diameter and prominence of the pulmonary conus area and a relatively small aortic shadow. Negative barium enema and barium meal study.

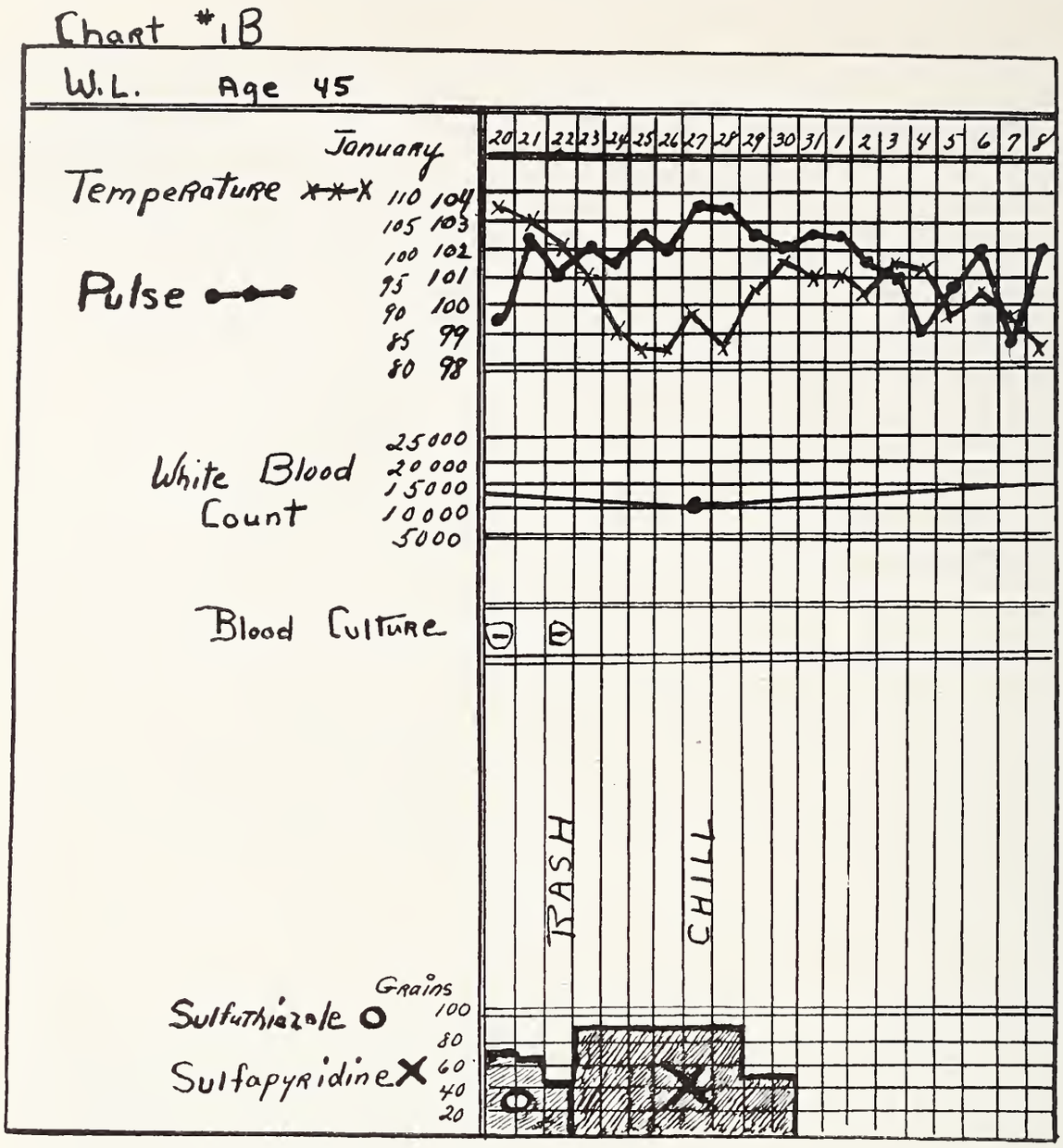
Electrocardiogram

January 11, 1941. Rate of 100 Normal P waves and P-R interval. Good voltage of the QRS complexes. T waves normal except for inverted T-4.

Typhoid vaccine was administered on seven occasions during February, 1941, with dosage and results as follows:

February 15th—100,000 bacteria given i. v.

February 16th—300,000 bacteria given i. v.



February 17th—1,000,000 bacteria given i. v.

February 18th—3,000,000 bacteria given i. v

February 19th—5,000,000 bacteria given i. v. —Chill an hour later.

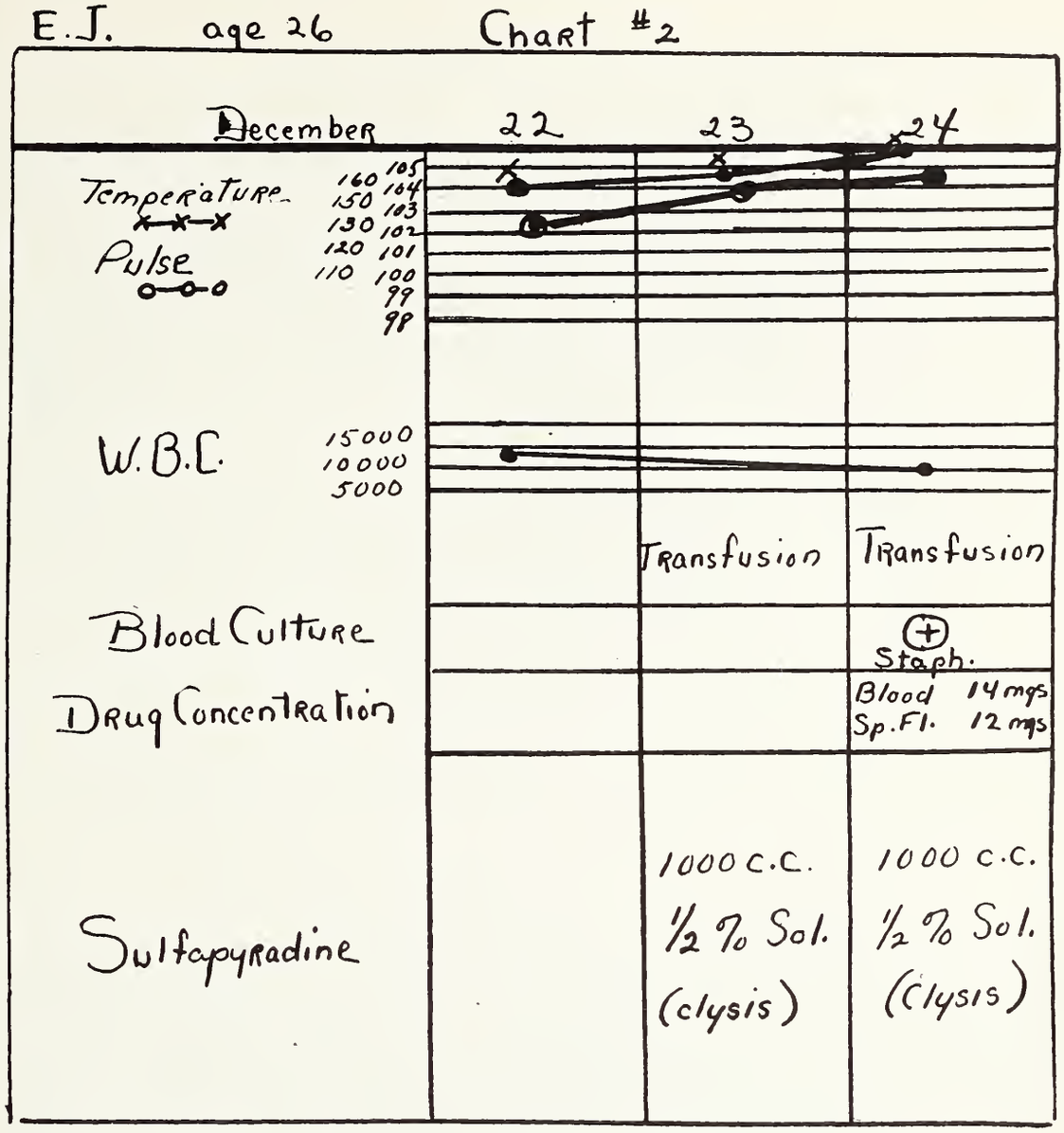
February 21st—5,000,000 bacteria given i. v. —Chill an hour later.

February 24th—10,000,000 bacteria given i. v.—Chill an hour later (severe).

The patient was discharged improved, March 3, 1941, but he almost immediately developed acute congestive heart failure with edema of the legs, epigastric pain, dyspnea and orthopnea. When readmitted on March 10, 1941, he had a blood pressure of 90/70, a regular pulse with rate of 100, a normal temperature; but he was cyanotic and dyspneic, had an enlarged liver, ascites and edema of the legs. Digitalis, diuretics and bed rest resulted in temporary improvement in his condition of cardiac failure but he continued to complain of epigastric distress and to have attacks of paroxysmal dyspnea, especially at night. The temperature remained normal for the first nine days. Thereafter, he ran a temperature of 100°-101° every afternoon. A blood culture taken March 27, 1941, showed no growth. Epigastric distress became more severe and finally was accompanied by intermittent nausea and occasional vomiting. He died suddenly at 3 A. M. on April 2, 1941.

Clinical Diagnosis

Rheumatic heart disease with mitral stenosis and congestive failure. Bacterial endocarditis.



Patient: J. H.

Age 72. Widowed, white female, who entered the hospital August 3, 1941, and died August 13, 1941.

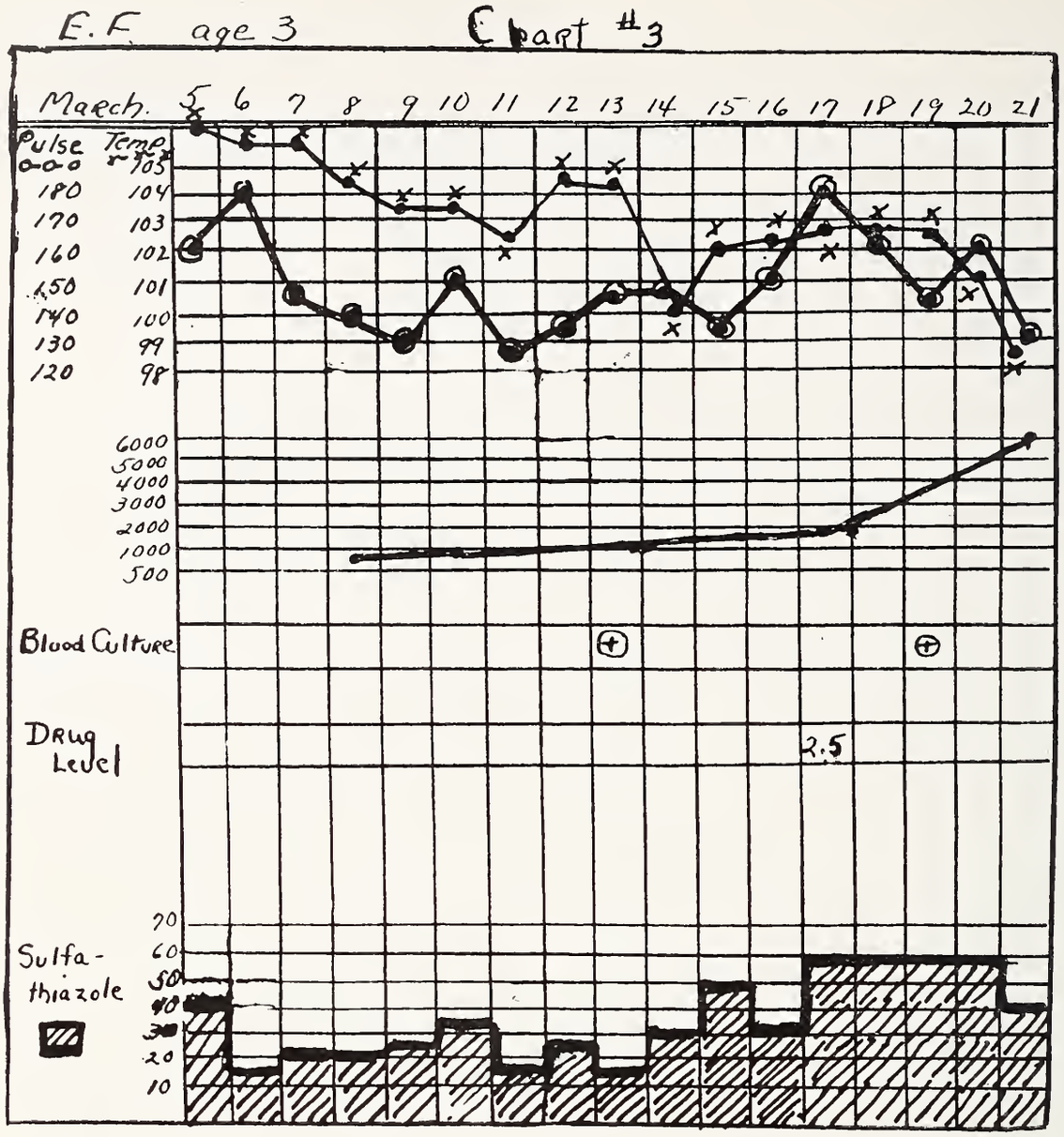
Chief Complaint

Chills, fever, generalized aches, headache and difficulty in talking.

Present Illness

Began about 9 days before hospital entry with generalized aches in the extremities and back and headache and a "mean" feeling all over. There was some fever on the first day and the condition was attributed to a grippy cold. With rest and decreased activity, the headache disappeared after 24 hours; but the backache and legache persisted and there was low grade intermittent temperature and night sweats. Her doctor was consulted on the morning of the fifth day of the illness, and at the time nothing abnormal could be demonstrated by physical examination. During the same afternoon, patient had a chill which lasted an hour followed almost immediately by a second chill which lasted two hours after which the temperature rose for a few hours to a maximum of 102.5°. Pyelitis, a central pneumonia, or bacteremia were considered as some of the most likely diagnoses.

W. B. C. 12,000. R. B. C. 4,180,000. Urine analyses showed VST albumen and few casts but no pus cells. Patient continued to have approximately an average of one shaking chill a day following which the temperature usually rose to 102° or 103°. Nothing could be detected on repeated physical examination, how-



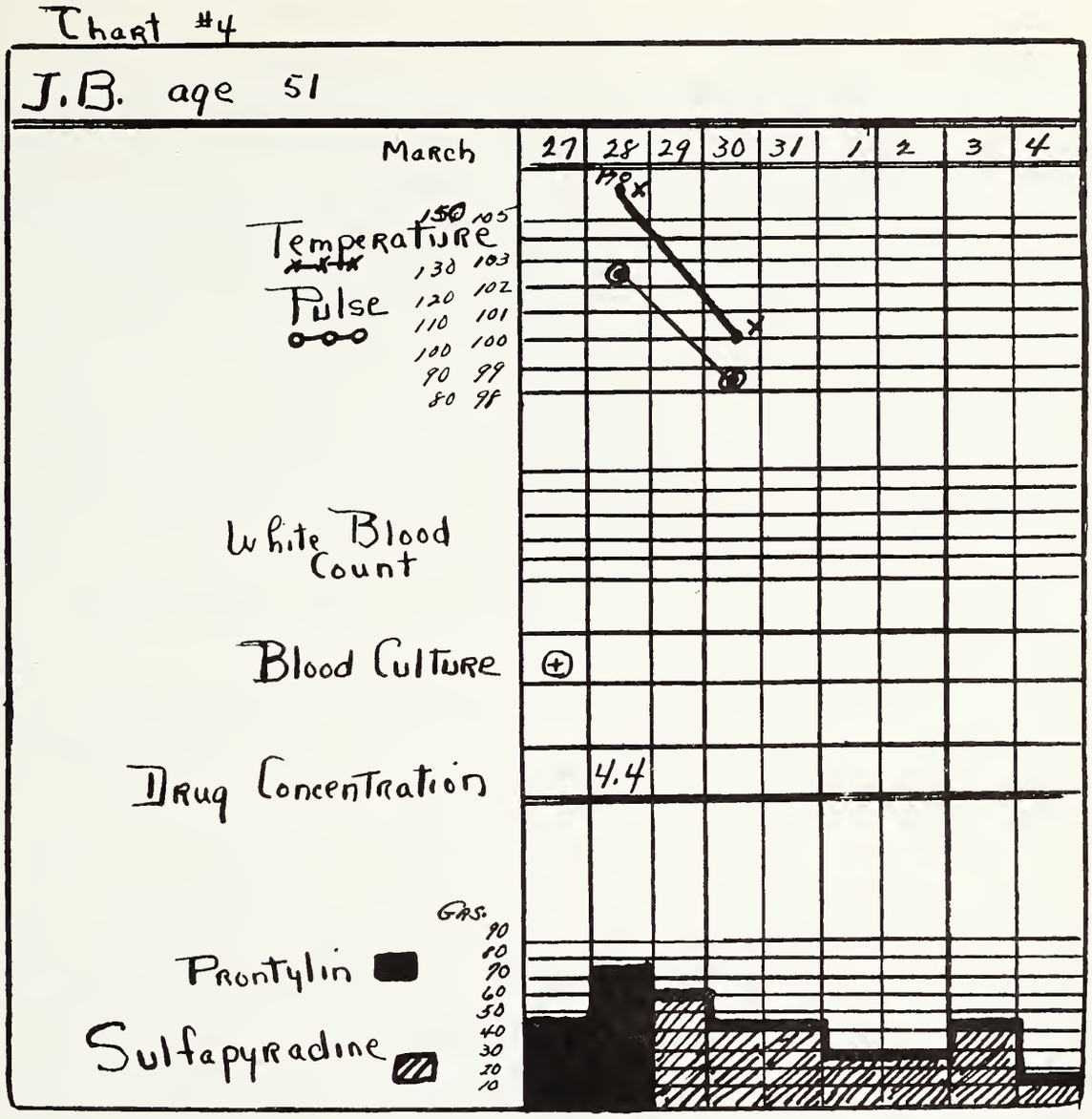
ever, and there was no recurrence of headache until the morning of entry to the hospital when there was a shaking chill followed by difficulty in talking, restlessness, and mental confusion.

Past History

Reveals that the patient during the past four years had had a moderate hypertension ranging between 150/84 to 190/90. When first seen in December, 1937, a diagnosis of hypertension and coronary artery disease was made. During the latter part of 1940 and early part of 1941, following over-indulgence in fatty foods she had attacks of epigastric pain which radiated through to the back and was thought to have gall bladder disease. Otherwise, past history not remarkable.

Physical Examination at Time of Entry

Showed a well developed, somewhat over-nourished female who had a temperature of 104.8°, pulse rate of 105 and respiratory rate of 31. Skin was hot and dry and there was some difficulty in respiration. Patient was semi-stuporous and unable to answer questions or to talk intelligently. Eyes were closed but resisted opening, pupils small, regular and reacted to light. Eyegrounds showed optic nerve heads normal without evidence of papilledema, and retinae showed no hemorrhages or exudate. The throat was negative, and teeth false. There was for the first time definite increased rigidity on anterior flexion of the neck. The heart rate was normal, the rhythm regular, but the sounds were rather distant and not of good quality.



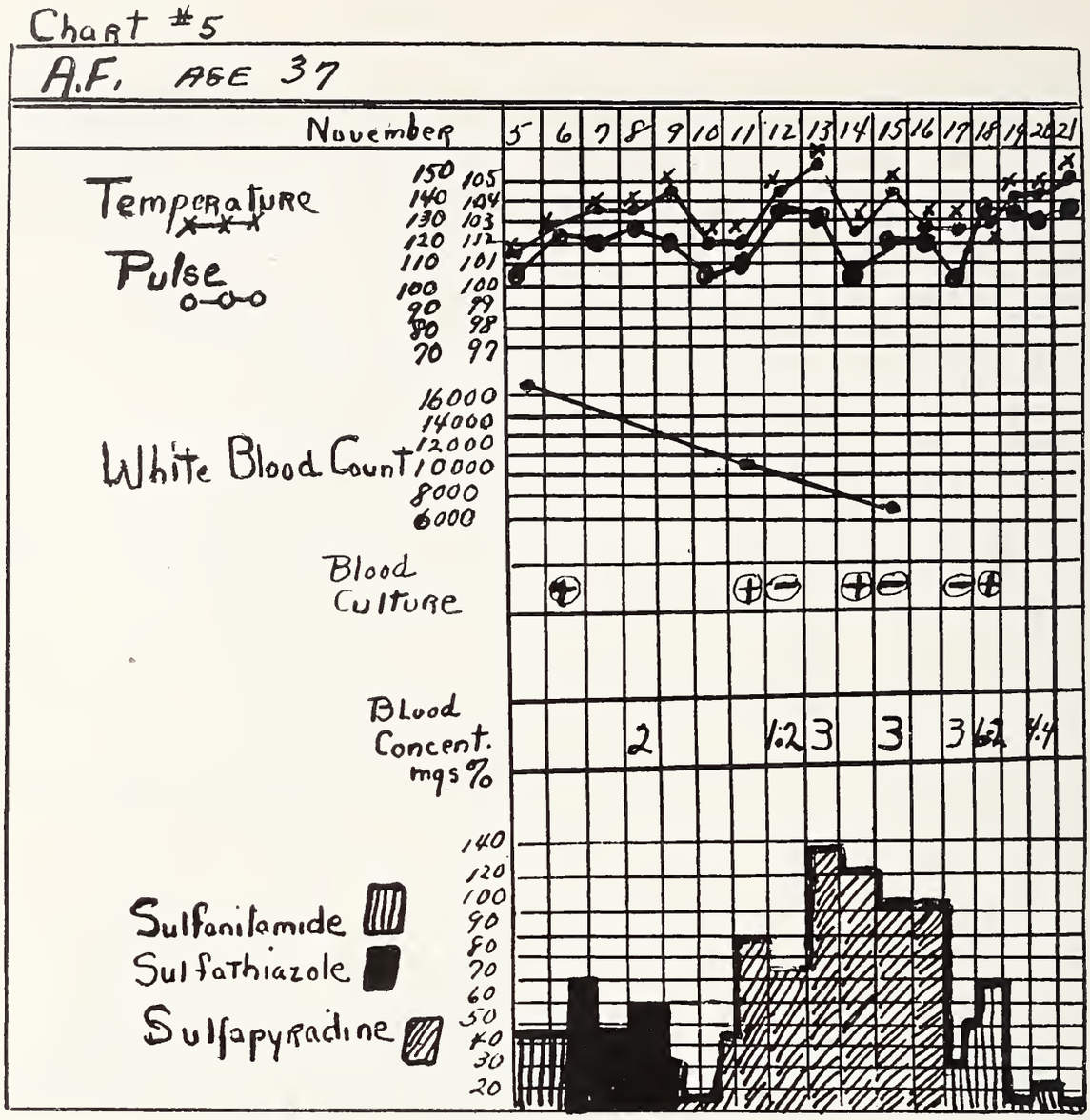
There was a loud systolic murmur audible over the entire precordium, but maximal over the mitral area. The heart was slightly enlarged to the left at the apex and the blood pressure was 160/80. No thrills were made out. Lungs were clear throughout. Abdomen was obese and rather flabby. Palpitation revealed no evidence of tenderness, muscle spasm, masses or enlarged abdominal organs. Reflexes were absent; Babinsky signs were negative and there was no clonus of the ankles. The skin was clear and there were no petechiae.

Course in the Hospital

Following entry to the hospital, it was felt that the patient probably had a bacteremia and that there was a possibility of meningitis. Accordingly, a lumbar puncture was done a few hours after entry and the fluid was found to be under an elevated pressure and to be definitely cloudy. Examination of the fluid failed to show any organisms. Blood cultures were taken at daily intervals.

The patient was then started on sulfanilamide, which was continued for a period of about 48 hours before clinical improvement and a drop of temperature to 103° and pulse to 80 were noted. Cultures of the spinal fluid were negative, but pneumococcus type XVI was grown out of the first blood culture. Since the patient had become very cyanotic and her NPN had begun to rise and the blood cultures remained positive with sulfanilamide therapy, it was decided to change to sulfadiazine.

Heparin. The stuporous condition of the patient and the mottled cyanosis and cold, clammy condition of the extremities suggested cerebral thrombosis and led to the instigation of heparin

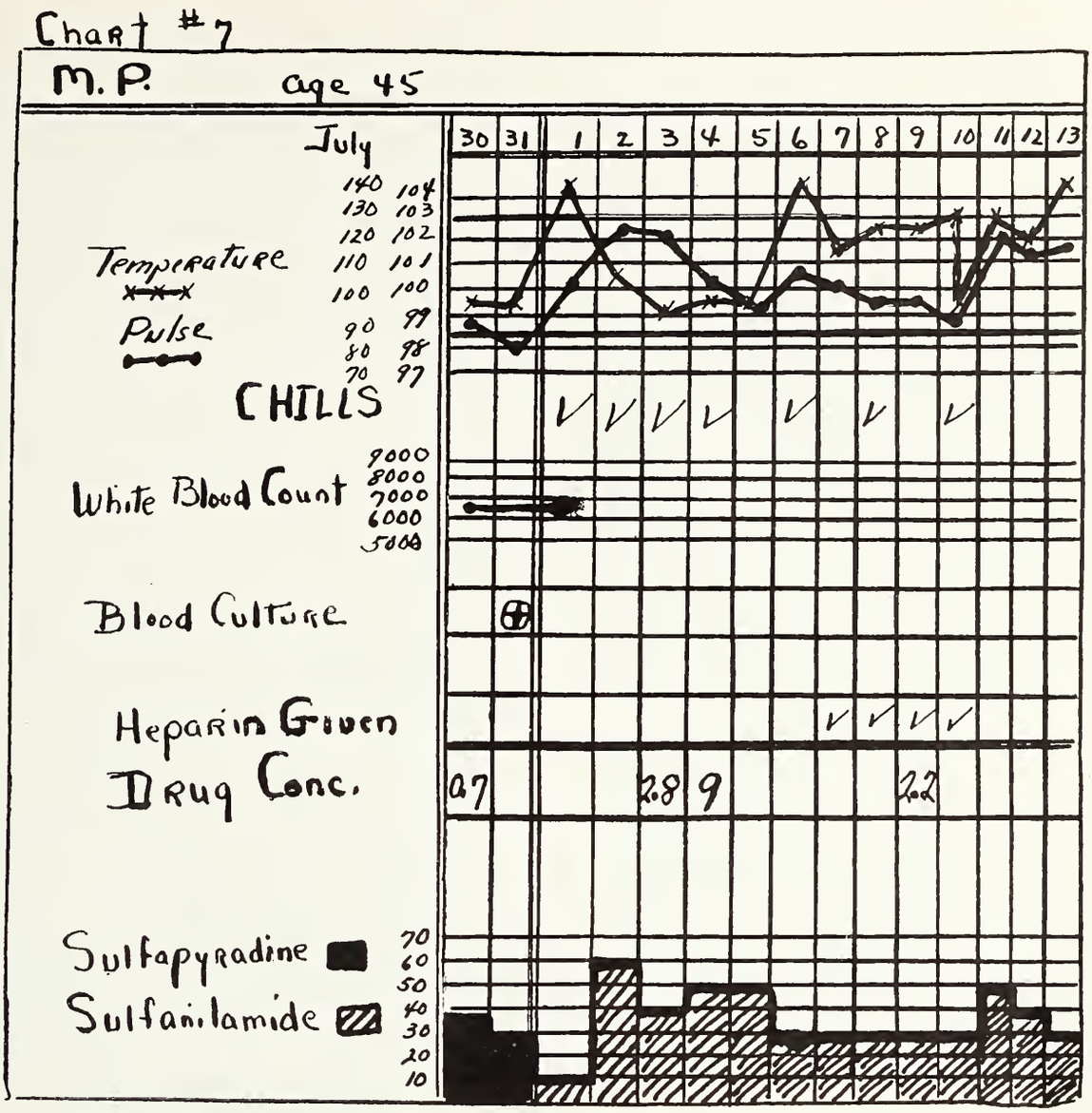


therapy on the second hospital day. Except for one period of 24 hours when the drug was not available, heparin was administered daily for the rest of her hospital stay.

At the end of 24 hours, the left lower leg and foot became cold and cyanotic and the dorsal pedic, posterior tibial, and popliteal pulsations could not be felt. Passive elevation and lowering of the left extremity and massage were instigated and the circulation gradually improved and there was a return of the arterial pulsations during the subsequent 48-hour period. On the fourth hospital day when heparin was not available, the patient rapidly lost her ability to move the right arm and leg. This hemiplegia began to improve again 36 hours after heparin treatment was resumed. On the eighth hospital day there was a marked and abrupt fall of the temperature to normal, pulse to 90, and respirations to 30. The spinal fluid was clear, rigidity of the neck had disappeared, consciousness had returned, and she was able to recognize friends and to ingest fluids and food. Subsequently, however, on the tenth hospital day the patient's condition did not seem so good and during the night and forenoon she began to fail, became cyanotic, developed shallow rapid respirations, weak thready, irregular pulse, lost consciousness and died on the eleventh hospital day.

Comment

These eight cases can best be separated into two groups for purposes of discussion. The three patients with staphylococcus and the three with pneumococcus endocarditis produced an acute fulminating disease with a short course;

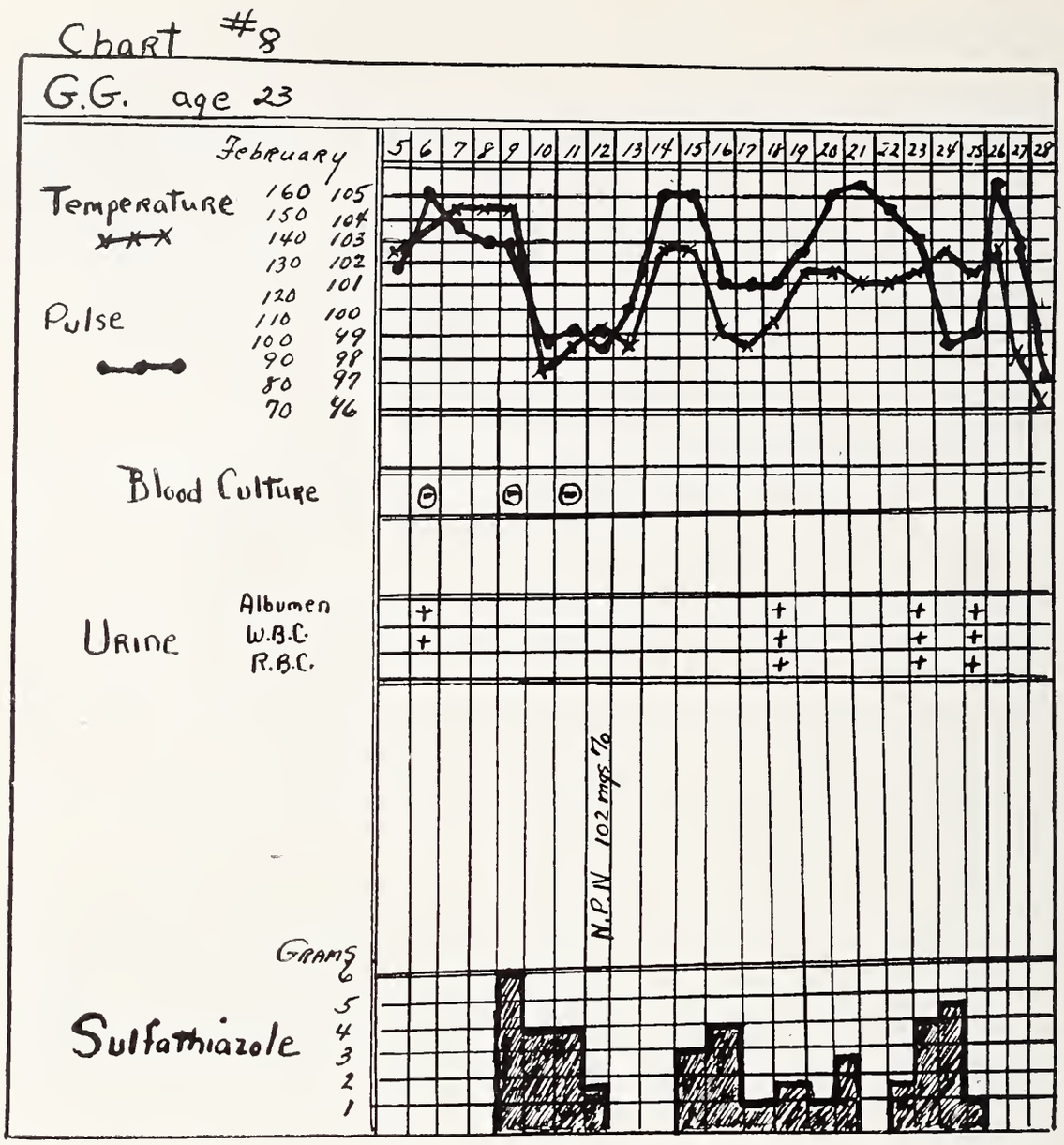


whereas the streptococcus viridans produced a subacute disorder of longer duration. In the former group the onset was characteristically abrupt, the course fulminating, with death occurring ofttimes before the causative organism could be identified and an adequate amount of chemotherapy administered. This difficulty was encountered in Case No. 2 and Case No. 6. Furthermore, embolic phenomenon with splenic, brain, pulmonary, kidney and peripheral infarction is a frequent and serious complication causing the death of many patients who might otherwise recover. Multiple infarcts were found as complications in Case No. 2, No. 3, No. 4, No. 5, No. 6 and No. 7. Serious septic infarcts occur in vital organs and may well continue to be responsible for a high mortality rate in pneumococcus and staphylococcus endocarditis.

It has been shown by Duncan and Faulkner[2] that sulfanilamide, sulfathiazole and sulfapyridine do not penetrate to any appreciable amount into previously formed vegetations and consequently cannot be expected to inhibit the incarcerated bacteria.

Sulfadiazine gave very promising results in Case No. 6 where the causative agent was Type XVI pneumococcus and there were numerous sizeable vegetations and one mitral ulceration which showed marked evidences of healing after only ten days of treatment. It seems fair to postulate that this patient might have recovered from her endocarditis and meningitis, had multiple septic emboli and basal or brain hemorrhage not occurred to complicate the situation.

The fact that certain strains of streptococcus viridans organisms are not susceptible to and previously formed vegetations are not pene-



trated by sulfanilamide, sulfapyridine and sulfathiazole would appear to be the explanation for most of the failures with chemotherapy in subacute bacterial endocarditis. Ulcerative lesions only were found on the heart valves in Case No. 5. No previously formed clot or vegetation was present to prevent contact of the sulfathiazole or the sulfapyridine in adequate concentration with the pneumococci on the heart valves. Consequently, it was most disconcerting to find that neither of the drugs had proven effective. Terry,[3] Fishkin,[4] Hollander,[5] and Heyer and Hick[1] have reported failure of sulfanilamide and sulfapyridine in the treatment of pneumococcus bacterial endocarditis. Furthermore, the authors[6] in a recent review of pneumococcus meningitis treated with chemotherapy called attention to the fact that sulfanilamide had proven, relatively speaking, to be a better drug and sulfapyridine a poorer drug than they were when the organisms were localized in the lung.

Whether or not the chemotherapy brought about the healing of the staphylococcus endocarditis in Case No. 1 will, no doubt, be a debated point. The characteristic febrile course with loss of weight, profuse night sweats and a positive blood culture are indicative of activity of the endocarditis at the time chemotherapy was begun. Doubtless, the recurrence of fever, the lack of repeatedly positive confirmative blood cultures and the fact that spontaneous cures with healing of the vegetations have occasionally been reported (Libman,[7] Capps,[8] and Welch[9]) will be presented by the more skeptical as reasons for not giving credit for the healing of this endocarditis lesion to the chemotherapy.

Heparin therapy, when administered, would appear to have been of questionable value. No benefit from its use was observed in Case No. 7, although in fairness it may be said that the treatment was probably not given in adequate doses or maintained over a long enough period to give it a fair trial.

Heparin was used in heavy and fairly continuous doses in Case No. 6. One must at least consider Heparin as one of the etiological possibilities for the hemorrhagic phenomenon observed on the base of the brain at post mortem. It is pointed out that Heparin was used because it was thought at first that the patient had meningitis and that the cerebral infarctions were due to thromboses in the basal vessels of the brain which are known to occur when there is meningitis, as again recently reported by Steele and Gottlieb. It was not recognized for several days that the meningitis and the other infarcts were, in reality, caused by septic emboli from the vegetations on the heart valves. Then it

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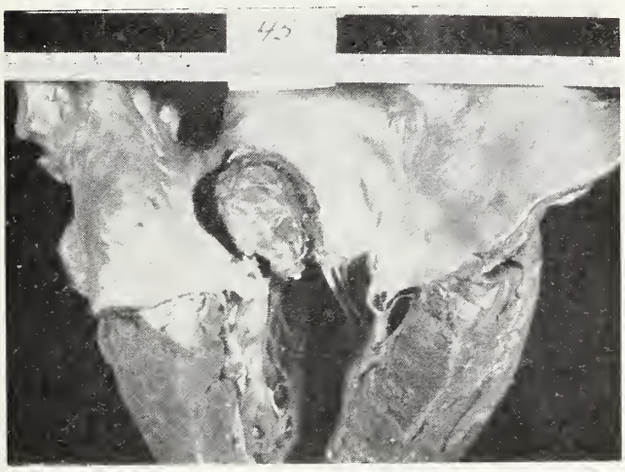
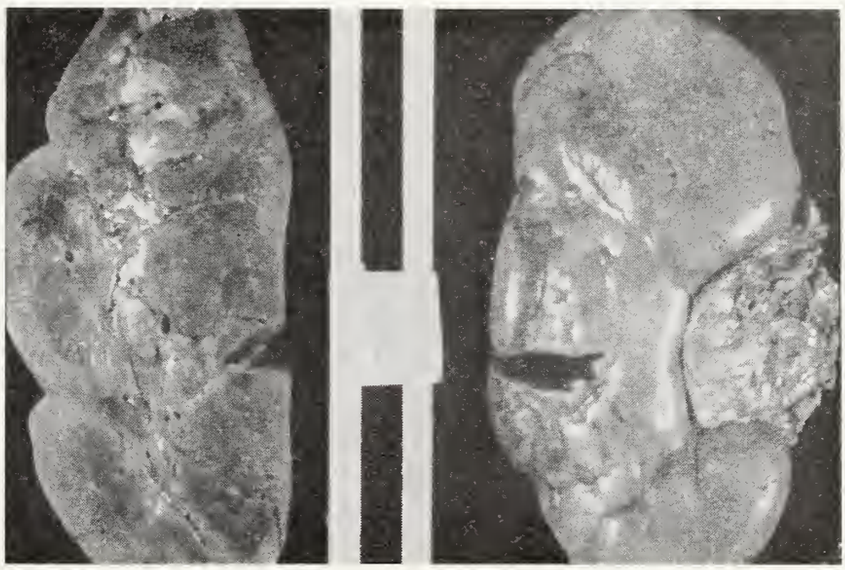


Case—W. L. # 1

Shows healed vegetation, mitral stenosis and "ball valve" obstruction.

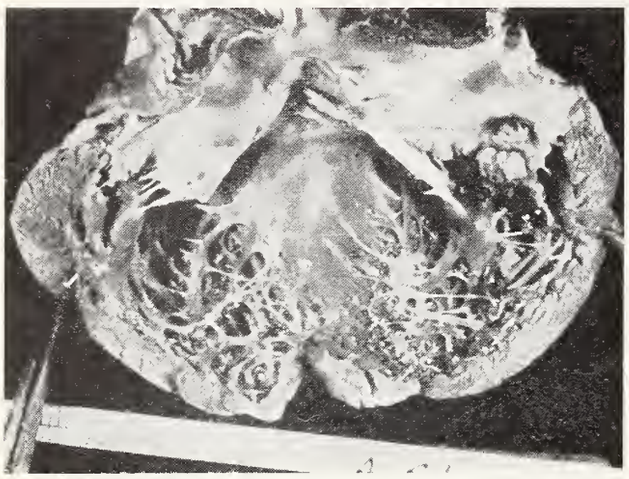
Case — E. J.

Shows partially organized vegetation with mitral stenosis.



Case—W. L. # 2

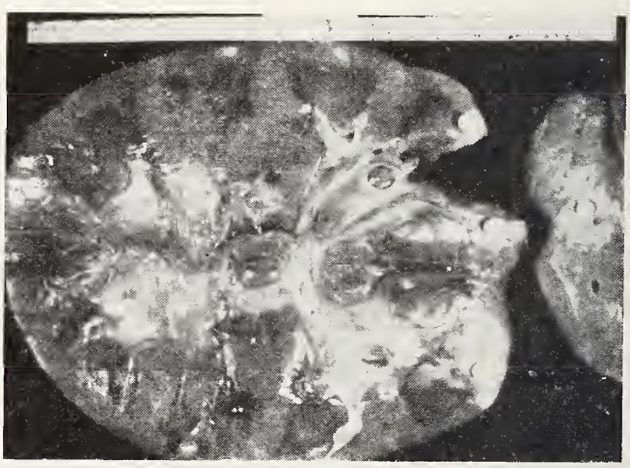
Shows well-organized and partly healed renal infarcts.



Case — E. F.
Shows soft vegetation of mitral valve.

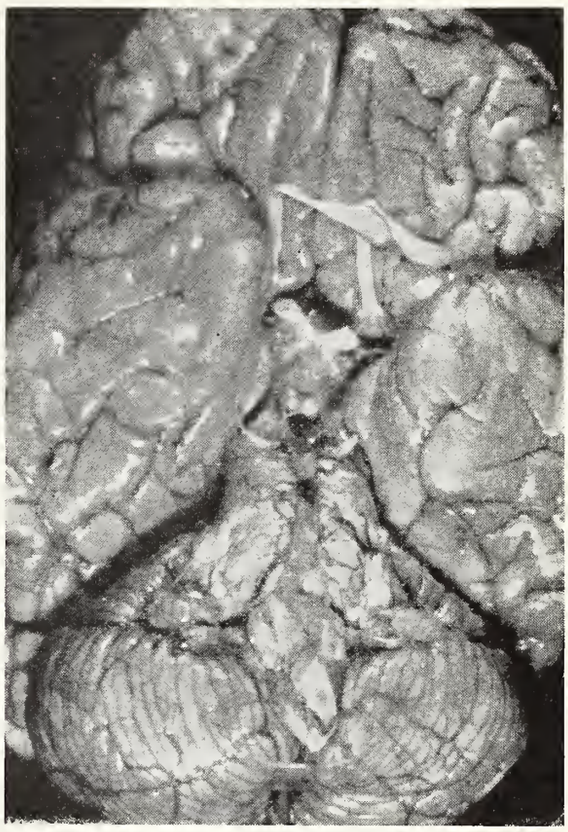
Case—A. F. # 1
Shows ulcerative mitral endocarditis.

Case — J. B.
Shows multiple mitral soft vegetations with moderate stenosis.



Case—A. F. # 2
Shows minute renal infarcts.

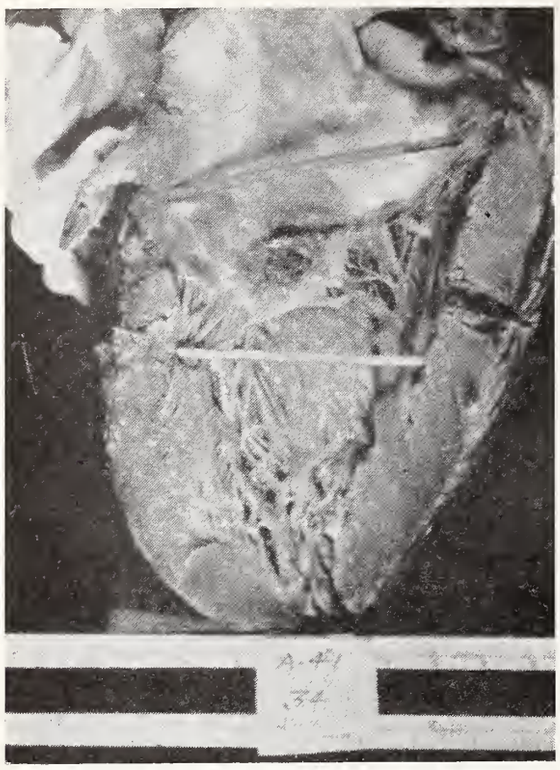
Case—J. H. # 1
Shows ulceration of mitral vegetation.



Case—J. H. # 3
Shows minimal residual evidence of meningitis involving intracerebellar lobes.

Case—J. H. # 2
Shows tricuspid valve with modified pannus-like fibrinous vegetation.

Case—J. H. # 4
Shows extensive subdural hemorrhages of probable Heparin etiology.



Case — G. G.
Shows soft, slightly organized mitral ulceration (Taken after fixation).

was decided to continue Heparin, since all previous embolic phenomenon had occurred either before heparin was begun or during intervals when the preparation was not available and the clotting time had returned to normal.

Considerable evidence is accumulating, then, which would appear to indicate that chemotherapeutic agents which are effective against an organism producing disease in one organ or location of the body may not be necessarily effective against the same organism producing disease in another organ or locality. This difference would not appear to be simply a lack of penetration of the sulfapyridine to the meninges as shown by adequate spinal fluid levels in numerous instances; or to failure of penetration of a previously formed vegetation as lesions on the heart valves were only ulcerative in Case No. 5 in this group. Should physicians continue to find that sulfathiazole and sulfapyridine are ineffective in the treatment of pneumococcus bacterial endocarditis, other drugs such as sulfadiazene should receive a thorough trial. The extensive evidences of healing on the vegetations in Case No. 6 after only ten days of therapy with sulfadiazene would suggest that it may prove to be effective against pneumococcus bacterial endocarditis.

Summary

1. The clinical course and post-mortem findings of eight cases of bacterial endocarditis have been presented.

2. The causative organism was the staphylococcus in three cases, the pneumococcus in three cases, the streptococcus viridans in one case and remained unidentified in one case.

3. The staphylococcus vegetations were healed at the time of autopsy in one instance (Case No. 1).

4. The vegetations showed remarkable evidence of healing in Case No. 6 when the patient had been treated with heparin and sulfadiazene.

5. It was of statistical interest to note that the eight cases were discovered in a series of 120 routine post-mortems over a period of 18 months.

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9. Welch, F. E., and Southwood, A. R., "Apparent Cure in a Case of Subacute Bacterial Endocarditis." *Med. J. Australia*, 1939, i, 392-394.

The President's Page

To the Members of the Maine Medical Association:

Now that winter is past and a belated spring is here, let's look forward to summer and the Annual Convention of our Association which is to be held June 25th, 26th, and 27th, at the Sam O set Hotel, Rockland, Maine.

At an Association Council Meeting held at the Sam O set Hotel, August 1st, 1943, we had a fine opportunity to inspect this hotel and have a personal talk with the manager. We found that it was admirably suited for this purpose, with ample accommodations for commercial exhibits, social functions, conferences, business and scientific sesssions.

For those of you who desire to combine business with pleasure, and who does not, there is an excellent golf course, tennis court, and opportunities for boating; for those who desire less strenuous forms of exercise there are the putting greens and croquet; and for the still less actively inclined comfortable rocking chairs strategically placed on a wide veranda command a superb view of the broad expanse of the Atlantic Ocean.

You owe it not only to yourself to go to this meeting, but also to our Association, for in order that this meeting shall operate efficiently the support and cooperation of every member is imperative. Also, not only does one profit by the various papers presented but the association with other medical men from all parts of the State can't help but broaden one's viewpoint and add to his knowledge.

Doctor Roland Lee McKay, although confronted by almost insurmountable difficulties, has arranged a program unsurpassed by any to date.

Make your reservations early. Let's go!

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Editorial

Opinion Poll Shows Confidence of People in American Medicine

The results of a public opinion survey, made to determine the opinion of the American people about medical care, reveal the confidence of the people in American medicine and constitute a challenge to medical leadership, *The Journal of the American Medical Association* declares in an editorial in its March 11 issue. The survey showed that less than one tenth of those interviewed thought of the American Medical Association as a "union" of physicians or as a "trust" or as being otherwise primarily a self-interested body. *The Journal* says:

"In July, 1943, the National Physicians' Committee employed the largest opinion research group in this country to make a comprehensive study of the people's opinion about medical care. The results of that study have just been made available. In making this survey the National Physicians' Committee has rendered a distinguished service to American medicine. The report should be of great help to medical leaders by pointing the way in planning for the extension of medical service. The report indicates the necessity for more education of the public regarding the issues involved in proposals for changing the nature of medical service. When people understand the issues, an overwhelming majority are unqualifiedly opposed to any such proposals as the Wagner-Murray-Dingell bill, which would establish federal control of medical practice. Even though the people sense the need for the extension of facilities designed to meet the costs of unusual or prolonged illness, only a small minority, as shown by this report, believe that compulsory sickness insurance would provide a satisfactory solution to the problem.

"Many of the questions in this research concerned the personal experiences of the people with medical care as now provided in the United States. The replies, in great majority, indicated that the people are deeply conscious of the value of individualized service in the effectiveness of medical care, that they want complete freedom of choice in time of illness and that they believe choice would be limited and restricted by administration of medical care under the auspices of the federal government.

"Out of this report came the conviction that many persons find difficulty in meeting bills for unusual or prolonged illness and desire to participate in plans or methods for insurance against the hazards of emergency illness. Already great numbers of people are familiar with the various prepayment plans for medical service available throughout the country. The investigations extended into many communities in which such plans are operating and covered the experiences of the participants. To summarize the many questions asked on this phase of the report: Persons who participate in prepayment plans approve them; in every instance such persons believe they are better off than their neighbors who have no such opportunity; the doctors in areas where such plans are in operation believe that the people are better off because of the operation of the plan. More than 50 per cent of the doctors in such areas stated that it would be a good thing if all industries would operate prepayment medical and hospital service plans for their employees.

"In a special survey paralleling the study of medical service, opinion was sought concerning the American Medical Association. More than three-fourths of the people who were questioned had heard of the American Medical Association, and about half of these defined its purposes with reasonable accuracy. In general, those who had heard of the American Medical Association expressed approval. The inquiry about the American Medical Association was made in the survey to determine the extent to which mention of the public education activities of the medical profession would tend to have a favorable or unfavorable influence on public thinking. The best evidence that the American Medical Association was considered a 'favorable symbol' was the fact that most people think of the purposes of the American Medical Association as being 'to sponsor new medical technics; to keep the standards of medical practice high; to give endorsement to acceptable medical prod-

ucts.' Moreover, less than one-tenth of the people interviewed thought of the American Medical Association as a 'union' of physicians or as a 'trust' or as being otherwise primarily a self-interested body.

"The report of this survey, which is available through the National Physicians' Committee, should do much to counteract the irresponsible and sometimes malicious criticisms that have been expressed recently within and without the medical profession. The scope and the accuracy of this survey cannot be questioned. The results are a challenge to medical leadership. Only through enlightened medical leadership can medical service and medical science continue to evolve in the United States beyond the high point that they have now attained. The advancement of medical science and of medical education is fundamental to the quality of medical service. Some of the proposals that have been made to federalize medical service, coming from outside the medical profession, would subsidize education and research. From within have come proposals to 'unionize' or 'commercialize' medical service. The professional status of medical care and medical science must be maintained. The economic factors involved in securing wider distribution of medical service must be studied and the widest possible application of these services secured. But even the economics of medical service must always be dependent on the science, the art and the practice of medicine."

Committee on Conservation of Vision

Acute Inflammatory Glaucoma

These short paragraphs which are appearing in the JOURNAL are an effort of the Committee on Conservation of Vision to make every practicing physician Glaucoma conscious.

It is felt by those most competent to know that there are altogether too many cases of Glaucoma seen late when hope of useful vision is gone. This applies nationally as well as for our own State.

Acute inflammatory Glaucoma is rather the easiest form of the disease to suspect and diagnose. It is characterized by sudden onset with discomfort or:

Pain—severe, radiates into temporal region.

Conjunctiva—injection of vessels about cornea, engorgement of the episcleral vessels.

Cornea—hazy and lusterless.

Pupil—dilated, pushed forward and reacts slowly to light.

Vision—cloudy with halos about lights.

Accommodation—sluggish.

Eyeball—harder than normal.

With a little practice the tension of the eyeball is easily determined with the fingers as follows:

> Rest the three outer fingers of each hand just above the superorbital ridge of the eye to be tested. Have patient close the eyes looking down and place each index finger half to three-quarters of an inch apart on the lid covering the eye. In this position palpate first one finger then the other. If the above is practiced on normal eyes at physical examinations one will develop a sense of touch which will give reliable information as to the pressure within the eyeball.

The various stages of acute Glaucoma are a prodromal, with suggestive symptoms as indicated above:—The chronic stage, or that stage between the acute attacks in which pain, visual disturbance and hardness of the eyeball are the prominent symptoms; and the last or absolute stage in which all vision is gone, the cornea very steamy, pupil widely dilated, the intraocular pressure greatly increased, and the eye very painful. Later degenerative changes or infection may develop. Without treatment these acute inflammatory phases of the disease will increase in severity and frequency until the aforementioned absolute stage is reached.

DIAGNOSTIC HINT

The pain of acute Glaucoma not infrequently causes nausea and vomiting and is often mistaken for a bilious attack or digestive disturbance.

Cancer Committee

Remarks on Cancer Control

Mortimer Warren, M. D.[1]

The Journal of the Maine Medical Association of June, 1934,[2] contains a series of reports from the hospitals of Kennebec County on cancer. These reports were summarized and interpreted by Dr. Risley. The conclusions and recommendations outlined by Dr. Risley form an instructive background with relation to a comprehensive cancer program which was then in its initial stages.

Our present set-up consists essentially of three elements[3]—(a) Acceptance by the state of its responsibility towards cancer as a problem; (b) The lay educational program of the Women's Field Army combined with financial assistance to the cancer clinics; (c) Implementation of professional activity by means of tumor clinics which represents performance made possible by the other two elements. These factors are in addition to and not in place of the valuable services of surgeons and others in their usual practice conducted largely through the facilities offered by hospitals.

A brief summary of the work of one clinic with which the writer has been associated since its beginning in the Fall of 1933 may serve to give a picture of the problem as it occurs in a single tumor clinic. From September, 1933, through the year 1937, there were 451 new patients, 265 of whom were afflicted with some type of cancer (including lymphblastoma and leukemia). One hundred and seventy-five of these patients died; 23 were incompletely followed, and 67 were living at the end of a five-year period. This gross salvage of 25 per cent is, I believe, an average result. This result is not too bad if consideration is taken of recurrent and late manifestations of cancer which a number of these patients presented when first seen, and of the actual cause of death, and of the expected mortality in each age group from all causes, and if one also considers those conditions such as lymphblastoma for which there is no known curative treatment.

In this group, nearly 60 per cent of the new patients showed evidence of cancer. The presenting problem was too much that of caring for obvious cancer rather than that of the care of early cancer and so-called pre-cancerous conditions.

The proportion of cancer to non-cancer as shown by our records of 1943 is reversed, with some 40 per cent diagnosed as cancer and 60 per cent as non-cancer.

In the group under consideration, accessible cancer, i. e., breast, skin, lip, tongue, mouth, cervix, and rectum, made up 191, or approximately 68 per cent of 265 cases. In 115 of these, or 60 per cent, the diagnosis was confirmed by tissue examination. The gross salvage was 35 per cent, or 68 persons.

The population of the Tumor Clinic as represented in the past four years gives a total of 4,415 visits of which 1,140 were new patients, and 3,128 were repeat visits. In the past two years, as is to be expected under existing conditions, there has been a definite, though not marked, reduction in volume of new patients, and in the number of follow-up visits to the clinic.

Hospital admissions from the Tumor Clinic for the years 1939 through 1942 averaged 160 per year, of which 64 per cent were cancer. During 1943, there were 104 admissions, of which cancer also represented 64 per cent. This is evidence of the present-day necessity of caring for as many as possible on the out-patient service and thus relieve the already overtaxed capacity of hospitals. In the hospital population of 1943, there were 338 cases of cancer, or about 4 per cent of all patients under treatment. Of these, the Tumor Clinic was responsible for the admission of 64, or 20 per cent.

The total problem in terms of cancer as a disease is shown by Dorn (The Incidence and Prevalence of Cancer of the Lung).[4] His investigations indicate that out of every 100,000 of the white population at any one time, 410 females and 340 males are under treatment for cancer, and that there are 290 new cases of can-

cer among white females, and 252 new cases of cancer among white males per 100,000 yearly. From this we can estimate the occurrence of some 4,600 cases yearly in Maine. The reported cancer mortality for Maine for the year 1942 was 1,298. If we assume 4 living cases for each death, we obtain approximately the same number of living cases of cancer at any one time on a population basis of 800,000.

A tumor clinic as such is an important contribution, though by itself, it makes a small dent in the total problem. Its utility can be further increased by wider extension of its facilities outside the hospital walls. This brings into view needed facilities for the care of non-resident individuals under forms of treatment which do not require bed care. Efforts should also be made to assure the use of opportunities nearest at hand, and in this effort close coöperation between clinics already established and those which may be established is necessary.

Terminal care and the care of those for whom palliative treatment only is indicated is a task the general hospital cannot assume. This important and humane part of a cancer program is yet to be solved.

Footnotes

(1) Chairman, Cancer Committee, Maine Medical Association.

(2) Maine Medical Journal, Vol. 25, No. 6, page 124, June, 1934.
Analysis of Cancer Work in Four Kennebec Hospitals, Dr. E. H. Risley.
Analysis of 43 Cases of Cancer Treated in the Augusta State Hospital during the Years 1932-1933, by Dr. V. T. Lathbury.
Analysis of Cancer Cases at the Gardiner General Hospital during the Years 1932-1933, by Dr. C. H. Farrell.
Analysis of Cancer Cases in the Thayer Hospital during the Years 1932-1933 by Dr. A. H. McQuillan.
Analysis of Cancer Cases in the Sisters' Hospital during the Years 1932-1933, by Dr. L. A. Guite.

(3) Cancer Control in Maine—The Journal of the Maine Medical Association, Vol. 33, No. 4, page 79, 1942, Dr. Mortimer Warren and Dr. Forrest B. Ames, and Dr. Herbert R. Kobes.
Eligibility of patients for Various Cancer Services—The Journal of the Maine Medical Association, Vol. 34, No. 3, page 51, 1943, Dr. Mortimer Warren and Dr. Herbert R. Kobes.

(4) The Incidence and Prevalence of Cancer of the Lung, by Harold F. Dorn, reprint No. 2503 from the Public Health Reports, U. S. P. H. S., 1943.

The Ninety-First Annual Session

The Program-in-Brief for the Ninety-First Annual Session of the Maine Medical Association to be held at the Sam O set Hotel, Rockland, Maine, Sunday, Monday and Tuesday, June 25, 26, 27, 1944, is published elsewhere in this issue of the Journal.

You have only to read this program to become convinced that the 1944 meeting is one that you can't afford to miss, so I will not go into detail but instead urge you to use the little time you can spare from these busy days to study this program and start your plan for attendance. I would also call your attention again to the letter from Prescott H. Vose, State Director, Office of Price Administration, relative to the use of gasoline for the purpose of attending the meeting in June, which was published in the April issue of the Journal—page 74—and which is self-explanatory.

A complete program will be published in the June issue of the Journal.

Frederick R. Carter, M. D.,
Secretary.

Tuberculosis as a cause of death among the wives of men who died of the disease is almost three times as high as it is for all women. Among sisters, the relative frequency is 2.3 times as high. — Antonio Ciocco, M. D., *Human Biology,* May, 1941.

At the present time the greatest need for health action is where the greatest saving of life and suffering can be made. Here I would place first, finishing the job in the control of tuberculosis. — Thomas Parran, M. D., Surgeon-General, Hospitals, Aug., 1940.

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Francois J. Faucher, M. D., Grand Isle
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, Edward Thegen, M. D., Bucksport

Kennebec
President, Clarence R. McLaughlin, M. D., Gardiner
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Abbott J. Fuller, M. D., Pemaquid

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, Pierre B. Aucoin, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Manning C. Moulton, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Lester F. Norris, M. D., Madison
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Waldron L. Morse, M. D., Springvale
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Cumberland

The last meeting of the Cumberland County Medical Association was held at the Lafayette Hotel, on the evening of April 26, 1944. Dr. Albert W. Moulton, President, presided.

The President appointed Dr. Walter E. Tobie to draw up resolutions on the death of Dr. Charles H. Hunt of Portland; Dr. George O. Cummings to draw up resolutions on the death of Dr. J. Calvin Oram, and Dr. Frank A. Smith to draw up resolutions on the death of Dr. George M. Woodman.

A communication from Dr. Carter, Secretary of the Maine Medical Association, was read, with regard to the use of automobiles by the members in travelling to and from the Maine Medical convention at Rockland in June. This letter states that automobiles may be used by the doctors, but it was recommended that rides be shared as much as possible.

The society was informed that 50-year medals would be presented at the annual meeting of the Maine Medical Association to two members from Cumberland County, namely, Drs. Harvey Howard of Freeport and John L. Pepper of South Portland.

It was voted that Maurice J. Dionne, M. D., of Brunswick, be accepted to membership by transfer from the Androscoggin County Medical Association.

The secretary then announced that in a conference with Captain Fish of the Portland Armed Forces Induction Center at the Stevens Avenue Armory, help was requested from the doctors in the county in aiding in the examination of inductees. Drs. Ralf S. Martin and George A. Tibbetts were appointed to study the problem, confer with Captain Fish, and find means to appoint doctors to the Induction Board.

The principal speaker of the evening was Dr. E. E. Holt, Jr., who read a paper on a plan for prepaid medical care in Maine. This plan has been tentatively arranged by a committee appointed by the councilors of the Maine Medical Association at their October meeting. Those appointed were: Dr. Piper, Chairman; Dr. Currier C. Weymouth, Dr. F. T. Hill, Dr. W. E. Kershner, and Dr. E. E. Holt, Jr. According to the plan, benefits would be paid to participating physicians for surgical procedures, and would only include medical care after 7 visits were necessary. A fee schedule was announced, and the privilege of the patient in asking for a waiver, in order that additional fees might be paid the physician by the patient in unusual cases, was described. The rates were: $.85 per month for a single person, $1.70 a month for a married couple, and $2.00 per month for a married couple and family. Dr. Holt emphasized that any plan must be endorsed by the Maine Medical Association, and have the approval of the majority of the practicing physicians of Maine, in order to be successful. He stated that the Associated Hospital Services would take over the underwriting of this plan, but in so doing they felt it necessary to include the osteopaths. In order to formulate a plan entirely controlled by the doctors, an enabling act would be necessary, and such legislation could not be made before May, 1945. Dr. Holt admitted that the plan was not complete, but it needed further study and remodelling to be more satisfactorily accepted by most of the physicians. The fee schedule as announced he thought was probably low in some instances, but was accepted as a temporary working basis, according to the Massachusetts plan. A discussion followed by Drs. Luther A. Brown, James M. Parker, Mortimer Warren, Ralf S. Martin, John V.

Continued on page 105

PROGRAM IN BRIEF

Maine Medical Association

Ninety-First Annual Session

SAM O SET HOTEL

Rockland, Maine

SUNDAY, MONDAY AND TUESDAY

June 25, 26, 27, 1944

SUNDAY, JUNE 25, 1944

4.30 P. M.

First Meeting of the House of Delegates.

8.30 P. M.

Dinner.

Guest Speaker, **Morris Fishbein, M. D., Editor, "The Journal of the American Medical Association."**

Subject: (To be announced.)

MONDAY, JUNE 26, 1944

Morning Session

9.00-9.30 A. M.

General Assembly:

President Oscar F. Larson, M. D., presiding

Invocation:

Rev. John Smith Lowe, Pastor of First Universalist Church, Rockland

Announcements:

Roland L. McKay, M. D., Chairman, Scientific Committee

Frederick R. Carter, M. D., Secretary

Conferences

9.30 A. M.-12.00 M.

I

TRAUMATIC SURGERY

Chairman: Morris E. Goldman, M. D., Lewiston

II

OBSTETRICAL AND GYNECOLOGICAL

Chairman: Magnus Ridlon, M. D., Bangor

III

THORACIC SURGERY AND PULMONARY INFECTION

Chairman: George E. Young, M. D., Skowhegan

IV

OTO-LARYNGOLOGY

Chairman: Henry P. Johnson, M. D., Portland

Luncheon

12.30 P. M.

Tables will be reserved for reunions of alumni of Boston University, Johns Hopkins, Bowdoin, McGill, Vermont, Tufts, Yale and Harvard Medical Schools, and members of the Tumor Clinics.

Afternoon Session

2.00-5.00 P. M.

SCIENTIFIC SESSION

1. Introduction of Visiting Delegates.
2. (Subject to be announced),
   Malcolm T. MacEachern, M. D., Chicago
3. Intra Vascular Thrombosis and Embolism,
   Joseph C. Doane, M. D., Professor of Clinical Medicine, Temple University, Philadelphia, Pa.
4. The Significance of the Rh Factor in Blood,
   Joseph E. Porter, M. D., Associate Pathologist, Maine General Hospital, Portland, Me.
5. Some Observations on the Treatment of Heart Disease,
   Paul Dudley White, M. D., Boston, Mass.

5.00 P. M.

Election of President-elect.

5.30 P. M.

Second Meeting of the House of Delegates.

Evening Session

7.00 P. M.

Dinner.

Guest Speaker, **Frank H. Lahey, M. D., Boston, Mass.**

Subject: The Management of the Surgical Lesions of the Terminal Ileum, Colon and Rectum.

President's Reception.

Dancing.

(OVER)

TUESDAY, JUNE 27, 1944

Morning Session

9.00 A. M.-12.00 M.

Conferences

I

ANNUAL MEETING OF THE MAINE MEDICO-LEGAL SOCIETY

President: D. M. Stewart, M. D., South Paris, presiding

II

SURGERY

Chairman: James M. Parker., M. D., Portland

III

FRACTURES

Chairman: Allan Woodcock, M. D., Bangor

IV

MEDICINE

Chairman: John O. Piper, M. D., Waterville

Luncheon

12.30 P. M.

Tables will be reserved for Past Presidents and County Secretaries.

Afternoon Session

2.00-5.00 P. M.

SCIENTIFIC SESSION

1. President's Address,
   Oscar F. Larson, M. D., Machias
2. (Subject to be announced),
   Thomas Parran, M. D., Surgeon General, U. S. Public Health Service
3. Recent Developments in the Treatment of War Casualties,
   D. W. Lyon, Captain (MC) U. S. N., Executive Officer, U. S. Naval Hospital, Portsmouth, N. H.
4. Medical Officer to be detailed from U. S. Army Medical Corps.
5. A Medical Metamorphosis,
   Adam P. Leighton, M. D., Portland

Evening Session

8.00 P. M.

Annual Dinner (Dress Informal).

Presentation of Fifty-Year Medals by President Oscar F. Larson, M. D.

Guest Speaker: (To be announced.)

Convention Rates
1944 Annual Session

Sam O set Hotel, Rockland, Maine
June 25, 26, 27, 1944

$9.00 a day per person. This rate includes all extras, with the exception of golf for which a special rate of one dollar a day is offered.

The Sam O set offers everything in the line of recreation and sport; a golf course, heated salt-water swimming pool, tennis courts, and badminton.

County News and Notes—Continued from page 102

Ward, George A. Tibbetts, Henry P. Johnson, Adrian H. Scolten, Stephen S. Brown, Frederick R. Carter, and Thomas A. Foster. Dr. Foster made a motion, which was unanimously passed, that each member be furnished with a copy of the plan, for purposes of studying it and instructing their delegates to vote accordingly at a special meeting of the society, to be held prior to the June meeting of the Maine Medical Association. Dr. Foster also recommended that a letter be attached to this copy, emphasizing the importance of this problem, and recommending that the doctors give this their very careful consideration and study, and that they make every effort to attend the meeting.

The meeting adjourned at 9.45 P. M.

Respectfully submitted,

JOSEPH E. PORTER, M. D.,
Secretary.

Knox

The Knox County Medical Society has had a regular meeting each month. The usual idea is that one month we will have some prominent speaker from away, and the next month some member will prepare a talk.

In February, Dr. Rudolf Haas, from the Central Maine General Hospital in Lewiston, talked to us on "Meningococcal Infections." His talk was wonderfully clear-cut and so instructive that it seemed we should be able to differentiate cerebro-spinal meningitis from the other types by the history and clinical picture. An early diagnosis of the fulminating type may save a life, and in the ordinary case may abort the meningeal symptoms. Sulfadiazine is the drug of choice in the treatment. Dr. Haas was a very able speaker.

In March, Dr. Fuller read a paper on "Pernicious Anemia—A Review."

In April, Dr. Francis Thurmon, of Boston, spoke on "Dermatitis, with Emphasis on Contact Dermatitis." The lecture was well worth while and gave all of us a much more clear-cut idea of the possibilities for delayed reactions from contacts, and the way in which the different eruptions may occur in distant places.

Dr. Thurmon's visits are always enjoyed because of the discussions concerning skin diseases which always follow and last for a long time.

A. J. FULLER, M. D.,
Secretary.

Penobscot

The Penobscot County Medical Association held its regular monthly meeting on Tuesday, March 21, 1944, at the Bangor House, Bangor, Maine.

Following dinner a round table discussion was held on the subject of *Fractures.* This was conducted by Allan Woodcock, M. D., S. S. Silsby, M. D., and P. S. Skinner, M. D.

There were thirty-nine present.

FORREST B. AMES, M. D.,
Secretary.

Notices

State of Maine

Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of Physicians Licensed by the State of Maine, Board of Registration of Medicine, March 15, 1944.

Through Examination

Claude Armour Burnett, Jr., M. D., R. F. D. No. 1, Saco, Maine.

Angelo Carra, M. D., 186 Columbus Ave., New York City.

Through Reciprocity

William A. I. Greenlaw, M. D., Fairfield, Maine.

Robert Mallery, III, M. D., Alden Park Manor, Philadelphia, Pa.

Linus Joseph Stitham, M. D., Mars Hill, Maine.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. C. Higgins, M. D.*

St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Mortimer Warren, M. D.*

Waterville: *Sisters Hospital*
1st & 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*

Thayer Hospital
2nd & 4th Thursdays, 10.00 A. M.
Director, *E. H. Risley, M. D.*

The Journal
of the
Maine Medical Association

Volume Thirty-five | Portland, Maine, June, 1944 | No. 6

Preserve Present System of Medical Care

Adrian H. Scolten, M. D., Portland, Maine

Much has been said to convince the Medical Profession and the Public whom they serve that State or Socialized Medicine will become a reality in America. Those who have been reading extensively on the subject and who have practiced under State Medicine or where Medical Insurance plans are in operation believe that the present system of medical care as it is practiced in Maine today is far superior to any plan yet proposed or in operation in this country or elsewhere.

Before we accept any other plan, we should be convinced that there is need for a change and that this change will be for the best interests of the patients and to the best interest of the Medical Profession. Without the hearty co-operation of the medical profession, no medical service plan can be a success. Neither State or Socialized Medicine or any insurance plan can ever be put into operation unless a majority of the medical profession gives its approval and consent.

Before we give up our independence in Medical Practice and adopt a Medical Insurance Plan—because we fear that the bill authorizing State or Socialized Medicine will be passed by the Federal Government,—we should know something of the strength of the opposition to the passing of the Wagner-Murray-Dingell Bill. The opposition comes from all walks of life. Several pages could be filled with quotations, but I can use here only a few:

Senator C. Wayland Brooks, of Illinois: "The Medical Profession has done an outstanding job and should not be brought under the whims of bureaucracy. There is strong opposition being voiced at present to such legislation. By the passage of necessary war measures, many Constitutional rights of the citizen have been *temporarily suspended*. To establish a system which would make these powers *permanent* is not appealing to many members of the Congress."

Dr Fishbein, Editor of the Journal of the American Medical Association said on March 24, 1944, in Terre Haute, Indiana: "Regarding the Wagner-Murray-Dingell bill, which is known as the bill for 'Socialized' Medicine, it has never aroused any extravagant enthusiasm in this part of the country. American medicine has produced the lowest death rate, and the most advanced medical science in the world. The chief incentive of the scheme seems to be a life pension for everyone in medical practice, keeping a lot in that shouldn't be there, and the

building up of a regimented profession with gigantic financial reserves which will be under the control of a politically appointed poohbah. The nation appears restless under the operation of some other things in the same direction."

In Columbus, Ohio, on April 4, 1944, Dr. Fishbein said: "America's leadership in the medical world is being threatened by proposed legislation that would set up bureaucratic control of the Medical Profession."

"American medicine leads the world today and will retain that leadership in the post-war world," Dr. Fishbein said in an address before 200 members of the Columbus Academy of Medicine and their wives at a dinner meeting at the Seneca Hotel in honor of the academy's past presidents and 50-year members.

"The legislation," Dr. Fishbein asserted, "if enacted would have a bureaucracy in Washington abolishing a patient's free choice of physicians, would determine which hospitals would be acceptable for government funds, and would discriminate against certain medical schools."

Again in Toronto, Canada, Dr. Fishbein said: "The state frequently endeavors to control disease through the exercise of the police power, but that compared with individual treatment by individual physicians applying specific remedies is a costly and inefficient procedure."

"There is no evidence that the medical bureaucracy which would be set up would give the kind of service that Americans have come to expect," he added.

"He termed the bill fallacious and out of accord with the American system of government."

The following is quoted from the April 25, 1944, *Bulletin* of the A. M. A's Council on Medical Service and Public Relations, G. Lombard Kelly, Secy.

Congressman Dingell, co-author of the current Wagner Bill, recently stated that the opposition came from a "reactionary minority in the medical fraternity." Note particularly that word "Minority," and then take a look at the record. There are 295 practicing physicians in Congressman Dingell's home district in Detroit. They were polled with this result: 10 were in favor, 9 were undecided, and 265 were against the bill.

In Senator Murray's state, Montana, the third co-author of the Bill was deserted by the members of the medical profession. There are approximately 400 doctors of medicine in the state, and all but one county medical society voted *unanimously* against the bill.

* * *

We are living in a period when social reformers, economists, hospital insurance associations, and government agencies are striving for means to control the practice of medicine. Some are more interested in what they can get out of it than in the welfare of those persons whom they profess to serve.

The reactions of some members of the medical profession in California where a pre-payment plan known as the California Physicians' Service is in operation are reflected by the magazine, *California and Western Medicine.*

Morton R. Gibbons, Sr., M. D., Medical Director of the California Insurance Plan wrote in this magazine recently: "You must be more or less familiar with the '57 varieties' of state medicine in existence at last reports. Most of the important countries of the old world have had state medicine, in some form. No two were alike, the best reason for which is that none was satisfactory. At last report, Germany's system—the oldest—reported that absence due to sickness increased 40 per cent. Physicians' incomes were so meagre that suitable young men would not study medicine. England did not wish to abolish her system, but hoped it could be much more satisfactory, yet did not know how it could be improved."

Dr. Morton R. Gibbons, Sr., also said in his report in the *California and Western Medicine:*

"This country (America) never adopted state health insurance, because the people naturally want to be independent. Lately, that attribute (independence) is being worn down—unless recent elections mean something.

"The Wagner-Murray bill provides for control of the whole problem by the U. S. Public Health Service. Doctor Parran told me that he had no inkling of this bill until it was shown to him the day before it was introduced. He said

he would have none of it. The Public Health Service views it with horror. The bill is probably too great a bite to take all at once, and therefore will defeat itself. It is another example of an effort to attain fulfillment of a delightful dream without knowledge of the obstacles in the path.

"I cannot leave consideration of 'what we have' without reference to the Workmen's Compensation Laws (California's especially). The California law has attributes comparable to state health insurance. This law went into effect thirty years ago. It has been modified, altered, amended, not because of changing conditions, but because it was not perfect. It is not perfect yet. It was at first administered by high-minded men. It has been from time to time dominated by politics and administered in a manner quite contrary to its intent, and the wishes of the people."—Morton R. Gibbons, Sr., *California and Western Medicine* issue.

Under any state medicine or even an insurance plan, doctors may have to spend as much time making out blanks and justifying their actions to a Board of Directors or to the Administrator of the Plan as in treating their patients. The present privacy existing between the patient and the doctor will be gone. Confidential matters will be on record outside of the doctor's own office. Today what the patient tells the doctor is completely confidential, and a patient trusts his doctor as much as he does a member of the clergy. Today he need fear no leaks.

The question also arises whether so drastic a change should be made when so many doctors are in the armed forces and have no opportunity to vote for or against it. Conversation with doctors in the armed forces in this country and letters from those in foreign countries support the conviction that they wish to come back to the present free and unregimented way of practicing medicine. They are fighting a war in order that America may be kept free from dictation. They, like those of us who were in the last war, have had more than their fill of regimentation and dictation. They long to go back to independent living and freedom of enterprise.

California, during its early experience in the field of Voluntary Medical Insurance found itself short $1,350,000. The insurance charge to the patient each month was not high enough and the doctors were forced to take one-half their promised fee.

Many California doctors and their patients are not enthusiastic about the California Physicians' Service. Even now after five years of experience, many physicians and patients wish they had never been sold on the idea.

What is back of all this propaganda for Socialized Medicine or Voluntary Medical Insurance, its substitute measure? This is something which only those who are "in the know" can answer.

* * *

In three years of Post Graduate study in New York City, just before we were pushed into this war, I was daily associated with well-trained, high-minded refugee physicians, some of whom were deeply thankful that they could live and practice in a freedom loving country where there was no "middle man" to interfere with the doctors' judgment, and whose salaries and overhead must be added to medical costs.

We have to admit that the most efficient form of government is a dictatorship, but Americans do not want it. There is an uncanny wisdom in the Voice of the People, and in our Democratic procedures. Our present method of Medical practice should be preserved because it is more simple, more direct, and more satisfactory than any of the imported European varieties. European idealogies cannot successfully be foisted upon the American people.

Under our time-tried medical practice, American physicians and surgeons have enjoyed unrestricted freedom and independence yet they have led all other countries in giving consistently high quality medical service to all the people without fear or favor, and to the indigent, without price.

American doctors have the respect and confidence of their patients and a record of achievement which is unequalled.

We have a noble heritage. We must seek to remain free in our thinking, unrestricted in our ways of doing, and as unmolested by bureaucracy and outside dictation as is possible.

The President's Page

To the Members of the Maine Medical Association:

In writing my last President's Page I find it difficult to express myself properly in regard to thanks due those members of our society who have been so helpful during the past year.

Difficulties have arisen which in no way could be avoided.

I deeply regret not being able to attend more county meetings but this was unavoidable due to extreme shortage of physicians in this sector and being geographically located away from medical centers.

Association with members of the Council during the last three years, and this year as President, has been a great pleasure.

We have tried to keep the practice of medicine in this State on the same high plane it has before enjoyed, and I am very sure that under the guidance of R. V. N. Bliss, M. D., our incoming President, better things may be looked for during the next year.

Let us not forget that out of today's crisis' are coming developments of tremendous importance and there is no doubt that medicine can make its power felt providing there is the necessary combination of leadership and coöperation from its members. The "strength in unity" idea will be all important during the next few years.

The art of living does not necessitate an environment in which everything one wants is easily accessible. A well worked out equilibrium of all the forces that play upon us is a fundamental necessity.

It is the inner values that count most and it is to them that civilization should turn. In the words of our beloved Doctor and Poet—Oliver Wendall Holmes

Lord let War's tempest cease,
Fold the whole Earth in peace
Under thy wings!

Oscar F. Larson, M. D.,
President, Maine Medical Association.

Editorial

The Ninety-First Annual Session Program

The Program for the Ninety-First Annual Session, to be held at The Sam O set, Rockland, June 25th, 26th, and 27th, is published elsewhere in this issue. This excellent program has been arranged by Roland L. McKay, M. D., of Augusta, who "took over" when the Chairman of the Scientific Committee, Eugene E. O'Donnell, M. D., of Portland, found it necessary, because of the pressure of work, to resign.

In this program is something of interest to every member; general practitioner and specialist alike. The Conferences cover every field of medicine. The Scientific Sessions, and the Evening Programs, feature many outstanding speakers.

The Council report for the year will be presented by the Chairman, John O. Piper, M. D., of Waterville, at the First Meeting of the House of Delegates on Sunday, June 25th at 4.30 P. M. The Prepaid Medical Care Plan, as outlined by a special committee appointed by the Council, will be on the Order of Business for this First Meeting of the House, as will the report of Thomas A. Foster, M. D., of Portland, Delegate to the American Medical Association, reports of Delegates to Out of State meetings, Committee Reports not published in this issue of the JOURNAL, and the Treasurer's Report.

Election of the President-elect will take place on Monday, June 26th at 5.00 P. M., followed by the Second Meeting of the House of Delegates at 5.30. The Order of Business for the Second Meeting of the House will include the Nominating Committee's report of Standing Committees for 1944-1945, for consideration and action by the House, the election of Councilors for the Third and Fourth District, and Unfinished Business.

The Association's Fifty-Years' Medals will be presented, at the dinner Tuesday evening, to Drs. Albert W. Plummer, Harvey Howard, John L. Pepper, J. Albert Lethiecq, Eugene B. Sanger, William E. Lightle, William W. Smith, and Arthur J. Stimpson, who have completed half-a-century in the practice of medicine, but who in the way they are "carrying on" during these trying times makes many a younger man "sit up and take notice." A ten-year service bar will be presented at this time to James S. Sturtevant, M. D., of Dixfield, who received the Fifty-Year Medal in 1934.

Eighteen firms will present technical exhibits, bringing to you the latest developments in their various lines. They deserve the appreciation and support of every member. I believe that these exhibits are particularly important this year when it is difficult for these firms to send their representatives to you.

The letter from Prescott H. Vose, State Director, Office of Price Administration, published in the April issue of the JOURNAL, page 74, explains thoroughly the use of gasoline for the purpose of attending the meeting. It is needless for me to go into detail as to why the program outlined in this letter should be abided by.

The Officers of the Association are hoping for a 100% attendance — don't be the one to make it less.

Maternal and Child Welfare

Emergency Maternal and Infant Care Program

On April 23rd the Committee met with the Maternal and Child Health Staff of the State Board of Health for the purpose of clarifying some matters connected with the Government's Emergency Maternal and Infant Care Program. This Program is designed by Congress to provide maternal and infant care for families of men in the four lowest paid grades of the Armed Forces gratis and without financial investigation. Because this program sets up certain minimum standards of care and requires records, a consequent result should be the improvement of maternal care. This would reduce our infant and maternal death rate.

The maternal and infant mortality rate in this State is too high. Experience in operating the E. M. I. C. program here indicates that too many physicians keep poor records or no records at all. It seems to your Committee that there is a distinct relationship between these two facts. Poor recording will sooner or later lead to failure to recognize an impending complication. The time spent in setting down symptoms, signs, and treatment while the patient is in the office is negligible as this author can testify from long personal experience.

Now, how do we stand with the E. M. I. C. set-up? The Augusta office has now about 2,400 cases, 600 closed, 1,800 pending. Only about 100 are for infant care. It is authorizing care for 200 to 250 cases a month. Applications for infant care are increasing, now being about 50 a month.

The E. M. I. C. makes no pretense that it will make physicians and hospitals rich. The physician receives less than he would from private patients if the private patients paid one hundred percent. They don't, so the doctor will do better than break even. We believe that twenty E. M. I. C. patients will pay more than an equal number of private patients selected in order of occurrence. Even if this is not so, the doctor owes something to the families of men in the Armed Forces. There will be no extra fee for operative deliveries except that if a surgeon is called in for Caesarean section, he will receive $35.00 while the obstetrician will receive his full fee. It is a policy of the E. M. I. C. program not to pay more for any surgical procedure than is paid for an obstetric case.

The number of prenatal visits authorized will soon be seven instead of five, and $4.00 will be paid for the first. Urine, haemoglobin and blood pressure determinations will be required as well as Kahn tests and complete physical examination. The post-partum examination at six weeks will be required when practicable, and a $5.00 fee for this will be paid. This will raise the total fee to $45.00. Must the physician give prenatal care? He must if the patient presents herself in time. The "Emergency" in the E. M. I. C. refers to the War Emergency and not to obstetric emergency engendered by neglect.

The hospital fees are settled in the Augusta office with each individual hospital, and are based on the hospital's proven patient per diem cost. In general hospitals that means ward care.

The patient will not be permitted to supplement the fees to obtain more costly accommodations. Private nurses may be employed only on the physician's certificate of necessity, and authorization from Augusta must be obtained. Similarly the physician is not allowed to accept an extra fee from the patient.

The period of post-partum care of the infant required of the physician is to be reduced from six to two weeks. Premature infants will be considered sick infants and care authorized as for infant illness. The criterion of prematurity will be birth weight under five pounds.

Infant care at present is authorized only for sick babies. A sick baby is one requiring three visits or more. One-call illness will not be paid for by the Government. Where it is possible sick infants must be referred to the pediatric service of a general hospital. They will be on ward care, and the Government will pay only the hospital ward bill. There is now no provision for monthly examination of well babies at Government expense or for immunizations although these may come later.

Continued on page 126

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Francois J. Faucher, M. D., Grand Isle
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, Edward Thegen, M. D., Bucksport

Kennebec
President, Clarence R. McLaughlin, M. D., Gardiner
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Abbott J. Fuller, M. D., Pemaquid

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, Pierre B. Aucoin, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Manning C. Moulton, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Lester F. Norris, M. D., Madison
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Waldron L. Morse, M. D., Springvale
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Cumberland

A meeting of the Cumberland County Medical Society was held at the Lafayette Hotel, Portland, Maine, May 17, 1944. Dr. Albert E. Moulton, President, presided.

Five new members were elected, all of whom were transfers from other societies, Dr. George Geyerhahn of South Portland, Dr. Gisela K. Davidson and Dr. David Davidson of Portland, all from Oxford County; Dr. Joseph Cappello of Portland, from Washington County; Dr. Hirsch Sulkowitch of Portland, from the Massachusetts Medical Society.

The main discussion of the evening was opened by Dr. E. E. Holt, Jr., Portland representative on the special committee of the Maine Medical Association to study prepaid medical care in Maine. A plan which was drawn up by this committee, based on the Massachusetts plan which is already in operation, was presented to the members, in the form of a letter, by the Maine Medical Association. The plan was then discussed in sections; numerous questions were asked Dr. Holt, and some of the answers and legal questions were answered by Herbert E. Locke, Attorney. Many phases of this plan were strongly objected to by most of the members; in many instances changes were recommended. However, when a vote was called for as to how the delegates to the Maine Medical Association meeting should be instructed to vote, the society was unanimous in its opposition to this plan. The delegates from the Cumberland County Medical Association were then advised not to vote in favor of this plan at the annual meeting of the Maine Medical Association.

JOSEPH E. PORTER, M. D.,
Secretary.

Penobscot

The Penobscot County Medical Association held its regular monthly meeting on Tuesday, April 18th, at the Bangor House, Bangor, Maine.

The speaker of the evening was Dr. George C. Stattuck, Professor of Tropical Diseases at Harvard Medical School. Doctor Shattuck spoke on "Importable Tropical Diseases." This was treated from the standpoint of types of diseases that might be brought back by our returning soldiers.

There were forty-three present.

The Penobscot County Medical Association held its regular monthly meeting on Tuesday, May 16th, at Bangor, Maine.

This meeting was held in coöperation with the medical personnel of the Armed Forces in this section, the speaker being supplied by the Committee for Post-graduate Wartime Meetings. A surgical clinic was held at 3.00 P. M. at the Eastern Maine General Hospital with a discussion of surgical cases.

In the evening at the Bangor House, members of the County Association met with medical officers. The paper of the evening, presented by Dr. A. H. McQuillan, of Waterville, was entitled "Acute Abdominal Emergencies."

During the business meeting consideration was given to the proposed plan for prepaid medical care, copies of which had been sent to all the mem-

bers from the State Association. After considerable discussion it was moved, seconded and voted that the Penobscot County delegates to the Maine Medical Association meeting in June be instructed to vote against the plan as presented.

It was further voted that the delegates be instructed to support further investigation of the subject of prepaid medical care and find if other organized Insurance Companies might offer an acceptable plan.

There were forty present.

FORREST B. AMES, M. D.,
Secretary.

Washington

The regular spring meeting of the Washington County Medical Society was held at the St. Croix Hotel, Calais, Maine, on Thursday, May 25, 1944, at 6.00 P. M.

Following a delicious lobster dinner a short business meeting was held. The Maine Physician's Service—a Prepaid Medical Service Plan—was discussed at length. The eight members present voted against the service as being not applicable to Washington County.

Lt. E. T. Forsley, M. C., Camp Lee-Stephenson, Quoddy Village, Maine, guest speaker, gave a very interesting talk on "Medicine in the Navy," in which he outlined the workings of the Navy Medical Corps.

Three other guests were present: Lt. Edmund B. Curran of the Medical Corps; Lt. Gerald D. Thomas, Dental Corps; and James Littlejohn, Chief Pharmacist; all of Camp Lee-Stephenson.

ALLEN H. KNAPP, M. D.,
Secretary.

Book Reviews

"Manual of Dermatology"

A Military Medical Manual issued under the auspices of the Committee on Medicine of the Division of Medical Sciences of the National Research Council.

By: Donald M. Pillsbury, M. D., Marion B. Sulzberger, M. D., and Clarence S. Livingood, M. D.

With 109 illustrations.

Published by W. B. Saunders Company, Philadelphia and London. Price, $2.00.

Substantial increases (over peacetime) in dermatologic cases among personnel of the Armed Forces under current conditions of military expansion and actual warfare make the appearance of this manual on skin diseases very timely. The publication has for a prime objective the discussion of the management of dermatoses encountered in the Armed Forces. Actually, the authors concede, the Manual of Dermatology is intended for medical officers in an effort to aid them to deal satisfactorily with all but the most unusual or special dermatoses encountered in the very young, the very old, or in women. No effort is made to allow, by words or inference, the substitution of the manual for the standard textbook, rather it augments the more comprehensive publications. The manual is another in the series by the Research Council directed to Army and Navy medical officers in the field of military medicine.

"Small Community Hospitals"

By: Henry J. Southmayd, Director, Division of Rural Hospitals, The Commonwealth Fund, and Geddes Smith, Associate, The Commonwealth Fund.

Published by The Commonwealth Fund, New York City. Price, $2.00.

Penned in non-technical language and based on experience gained over a span of many productive years, this enlightening discussion on hospitals for small communities might well be perused by those individuals or groups who ponder the desire for, or need of hospital facilities in so-called rural environs. There is much of interest, too, for the medical student who expects to practice rural medicine. The book advances the theory, logically too, that lack of hospitals in smaller communities has driven many a physician to larger centers, leaving numerous small cities and towns without adequate medical protection. The publication delves deeply into all details of setting up small hospitals—from the advisability of such a move down to a discussion of finances and architectual principles. A convincing argument is advanced that the small hospital should not be allowed to pass from existence because, in addition to the protection it affords a community, it should serve, if expertly operated, as a post-graduate center for young doctors.

"War Medicine"

By: Winfield Scott Pugh, M. D., Commander (M. C.), U. S. N., Retired, formerly Surgeon, City Hospital, New York, as editor.

Published by Philosophical Library, Inc., New York City. Price, $7.50.

Exhaustive in the knowledge it imparts, yet comprehensive as to publication form, this symposium on war injuries and modern treatment of them should find a ready spot on the library shelf of the progressive practitioner. Dr. Pugh, as editor, draws upon the resources of prominent civilian, military and naval physicians and surgeons for his facts in the compilation of the volume. Articles on 37 different phases of war surgery comprise the opening 325 pages. A section is devoted to aviation and naval medicine while the concluding chapters revolve about general medicine as it concerns the war. Frequent illustrations augment the written word to give vivid pictorial portrayal to salient discussions. It is quite easy to determine, after reading this book, that the war has brought about new concepts in treatments of certain illnesses and injuries. How to combat these ailments is, of course, the underlying endeavor of the editor.

Continued on page 134

Councilor Reports

Report of Councilor, First District

To the Officers and Members of the Maine Medical Association:

Annual Report of York and Cumberland County Societies:

YORK COUNTY

Active Members, 37; Honorary Members, 2; Members in Military Service, 15.

New Member, Melvin Bacon, M. D., Sanford.

Members eligible for Fifty-Year Medals: Drs. William E. Lightle, William W. Smith, and Arthur J. Stimpson.

During the year there have been three meetings of the York County Society:

October, 1943—Speaker: Dr. William J. Bricklay, Medical Examiner of the North District of Boston. Subject: "The Cocoanut Grove Disaster."

January, 1944—Speaker: Dr. H. T. Pargeon of Portsmouth. Subject: "Rehabilitation of Naval Prisoners."

April, 1944—Speaker: Dr. James M. Parker, Portland. Subject: "Surgical Aspects of Gall Bladder Disease."

I regret that it was quite impossible for me to attend the meetings of the York County Society this year but hope that next year conditions will change so that it will be possible for me to attend.

CUMBERLAND COUNTY

Active Members, Paid, 120; Unpaid, 4; Members in Military Service, 47; Honorary Members, 7.

Members eligible for Fifty-Year Medals: Drs. Harvey Howard and John L. Pepper.

The Society has held three meetings:

October, 1943—Subject: Bill 1161.

March, 1944—Annual Meeting. The Society passed a resolution recommending that prescriptions for sulfa drugs be marked "not refillable." Guest Speaker: Dr. William Green, of Boston. Subject: "Painful Feet."

April, 1944—Plan for Prepayment Medical Insurance in Maine was presented by Dr. E. E. Holt, Jr. This plan had been arranged by a special committee appointed by the Council of the Maine Medical Association at a meeting in October.

Before each of the last two meetings, interesting and well-prepared clinics were held at the Maine General Hospital.

Respectfully submitted,

E. Eugene Holt, Jr., M. D.,
Councilor, First District.

Report of Councilor, Second District

To the Officers and Members of the Maine Medical Association:

As Councilor of the Second District, for Counties Androscoggin, Oxford and Franklin, I wish to report that collectively each Society is intact. Meetings have been held at various intervals, and each County has conformed to its By-Laws for the good of the Society. Because of the unusual amount of work demanded of each doctor, it has been difficult, in many instances, to hold meetings, and many of the meetings have had a small attendance. However, each Society should be complimented for what they have done under these trying conditions.

I would like, at this time, to stress the importance for a meeting of each of these County Societies, previous to the Annual June Meeting, for the purpose of instructing their delegates in the attitude of each Society concerning the Prepaid Medical Service Plan that is to be taken up at our Annual Meeting. This is something that is likely to concern each individual member in his future practice of Medicine. Therefore, let it be borne in mind that now is the time for each one of us to express our opinion, and it is important that each County Society instruct their delegates accordingly.

Respectfully submitted,

Currier C. Weymouth, M. D.,
Councilor, Second District.

Report of Councilor, Third District

To the Officers and Members of the Maine Medical Association:

The Councilor for the Third District has found no time to visit the Lincoln-Sagadahoc Society whose Secretary has advised that his group has required no counsel; that they have twenty-one Active Members, three Honorary Members, and five in Military Service. The exigencies of the times no doubt account for the rather infrequent meetings held, as has been the case with reference more especially to the meetings of the Knox County Society. The latter group has held monthly meetings with average attendance of about seven men; out of state speakers alternating monthly with local men. Eight active members in military service are sorely missed locally.

The Knox County Society is happy to have the parent State Association meeting within its precinct for the first time in the annals of medical history.

Respectfully submitted,

C. Harold Jameson, M. D.,
Councilor, Third District.

Report of Councilor, Fourth District

To the Officers and Members of the Maine Medical Association:

I would like to make the following report for the Fourth District.

Somerset County held one meeting during the past year. Active Members, 15; Honorary, 2; in Military Service, 6. One death; Harry W. Smith, M. D., of Norridgewock.

Waldo County held one meeting during the year. Active Members, 7; Honorary, 1; in Military Service, 2.

Kennebec County held three meetings during the year. Active Members, 55; Honorary, 1; in Military Service, 27. Two deaths; Silas O. Clason, M. D., of Gardiner; and James D. Nutting, M. D., of Hallowell.

A special meeting of the Kennebec, Somerset, and Waldo County Societies is to be held at Waterville, June 8th, to instruct the delegates regarding

the Medical Insurance Plan as outlined by the Council of the Maine Medical Association.

Respectfully submitted,

JOHN O. PIPER, M. D.,
Councilor, Fourth District.

Report of Councilor, Fifth District

To the Officers and Members of the Maine Medical Association:

As Councilor of the Fifth District, comprising Hancock and Washington County Medical Societies, I hereby submit the following report:

The Hancock County Society has seventeen Active Members, two Honorary Members, and eight in Military Service. They held eleven meetings during the year with an average attendance of ten members. Two new members were admitted to membership.

On March 10th, a joint meeting was held with the County Dental Society to discuss emergency medical care. Albert W. Moulton, M. D., State Director, Emergency Medical Service, Civilian Defense, of Portland, was present.

July 11th, Carl W. Ruhlin, M. D., of Bangor, read a paper entitled "Internal Derangements of Knee," with illustrated slides.

September 8th, W. F. Snow, M. D., Special Consultant to the U. S. Public Service, discussed Socialized Medicine, especially as carried on in England.

The Washington County Society has nineteen Active Members, three Honorary Members, and two in Military Service.

Four meetings were held during 1943: March 18th at Calais, Maine; May 18th at St. Stephen, N. B.; July 20th at Eastport, Maine; and September 30th at Machias, Maine.

Respectfully submitted,

HAROLD S. BABCOCK, M. D.,
Councilor, Fifth District.

Report of Councilor, Sixth District

To the Officers and Members of the Maine Medical Association:

Following is my report as Councilor of the Sixth District, Maine Medical Association.

The meetings of the constituent societies, Aroostook, Penobscot, and Piscataquis Counties have been published regularly in "The Journal." In addition to scientific subjects, each of the counties has spent some time in consideration of current medical problems. Aroostook County members wrote to their representatives in Congress to register opposition to the Wagner-Murray bill. Both Penobscot and Piscataquis accepted the medical contract of the Farm Security Administration. Speakers have been local and from other cities, and Penobscot County has had two meetings in cooperation with the War Committee for Post-Graduate Medical Meetings. Many of the members are in the armed services, but the remainder have continued with unabated interest and support of their constituent societies.

Respectfully submitted,

FORREST B. AMES, M. D.,
Councilor, Sixth District.

Committee Reports

Standing Committees

Public Relations Committee

To the Officers and Members of the Maine Medical Association:

Our relations with the public are said to be unsatisfactory. The voices of several powerful political groups have pronounced them so, although in our daily associations with the same public we hear very little complaint. We are asked to accept the interpretation of political groups who declare that the public demand politically controlled medical care. The existence of such a demand is at least open to doubt.

As a first step federal agencies are progressively gaining control of state health departments. Fortified by bureau regulations, evolved since the original act was passed, the existing scheme for the medical and surgical care of the pregnant wives of service men is now in operation throughout the state. It is denounced by some physicians, tolerated by others, embraced by none. It is unsatisfactory. If it is barometric of things to come, it deserves our active opposition. It implies bureaucratic distrust of our judgment and skill in treating our patients. It fixes a valuation and an hourly wage for our work which is below that of the average shipyard laborer. If its secret object is to drive us into adoption of labor union tactics, it is smart. If it is a serious valuation of our services to the public in the past, it is intentionally uncomplimentary.

Although legislation affecting laborers is never enacted without first consulting them or their representatives it is thought entirely proper to enact laws governing medical matters without consulting practicing physicians. Many of our state and national laws reveal a lack of understanding and an ineptitude of phraseology and construction which reveals their origin and makes them difficult to apply to everyday working conditions. Our own state laws and the Wagner-Murray-Dingell bill are no exceptions.

These attempts at coercion and subjugation of a great profession should serve to remind us that any law or agreement, whatever its origin, dealing with our relations with our patients, should be composed with great care and precision that it may apply its benefits and its restrictions equally to all persons and to all physicians lest it erect barriers between us.

Let us not lend our support to any law or agreement unless it can answer affirmatively our question—Will this law or this agreement when in full operation, result in a better quality of medical care for the people of this country?

Respectfully submitted,

R. BLISS, M. D.,
Chairman, Public Relations Committee.

Cancer Committee

To the Officers and Members of the Maine Medical Association:

I hereby submit my report as Chairman of the Cancer Committee. The Committee, as appointed last June, consists of:

Mortimer Warren, M. D., Portland (five years), Chairman, 1943-44; Magnus Ridlon, M. D., Bangor (one year); William Holt, M. D., Portland (two years); Arthur H. McQuillan, M. D., Waterville (three years); Julius Gottlieb, M. D., Lewiston (four years).

Again, as last year, I regret to state that "no meeting of the Committee has been held this year." The only contact members have had through their Chairman has been by correspondence. The pressing obligation of us all has been a local one of "maintaining the framework" of our Cancer Clinics.

I trust it will be possible to arrange for a meeting of this Committee before the annual meeting of the Maine Medical Association. We must keep in mind a long-time view of how best to meet the challenge of Cancer, along the lines of an accepted basis for the continuous development of a program which aims to correlate the activities of lay organizations; the State and the medical profession.

The Cancer Committee should assist the State Office of Cancer Control in extending its epidemiological activities and in developing to full use the tumor registry and biopsy program. It should carefully consider and adapt for our own purposes the well-developed machinery in use in Massachusetts, Connecticut, and elsewhere. In this respect the services of one who has had special training and experience in epidemiological research is required.

In the May number of the "Journal of the Maine Medical Association" appears a brief summary of the work of one Clinic presented by the Chairman for the Cancer Committee. Our Clinics have been in operation for something over ten years. We are, thereby, in position to analyze results with patients observed for five years or longer.

Respectfully submitted,

MORTIMER WARREN, M. D.,
Chairman, Cancer Committee.

Committee on Social Hygiene

To the Officers and Members of the Maine Medical Association:

I hereby submit my report as Chairman of the Social Hygiene Committee for the year 1943-44.

There has been no additional activity of this Committee since August 1, 1943, at which time the Chairman reported to the Council, at its annual summer meeting held at Rockland, the results of the Committee's conference held June 20, 1943, relative to the Venereal Disease Report Bill which became law April 9, 1943.

For full information regarding the above, I refer you to the September, 1943, issue of "The Journal of the Maine Medical Association," pages 180 and 181.

O. R. JOHNSON, M. D.,
Chairman, Committee on Social Hygiene.

Special Committees

Committee on Graduate Education

To the Officers and Members of the Maine Medical Association:

The following is the report of the Committee on Graduate Education for the year 1943-44.

The general let-down in program activities, both of the State and County Associations, this past year has been reflected in the work of this committee. The Home Study Courses, inaugurated last year, had to be abandoned, due to lack of interest, and coöperation upon the part of our members. This seems rather regrettable, particularly under the circumstances. Thirty-four applications for the courses, all outside the State, largely from physicians in Military Service were received after the courses had been discontinued.

No other activity has been undertaken by the committee as a whole.

Your Chairman has been serving on the New England Committee for Wartime Graduate Medical Meetings, and has been able to assign a number of our physicians as speakers at various military medical installations in this region. The purpose of these programs was to bring Graduate Instruction to the Medical Personnel stationed at the different posts. Each of the speakers has proven most satisfactory and many favorable comments have been received of their presentations. In all probability this work will be continued and more of our members will be asked to serve this coming year.

It is hoped that there will be a reawakening of interest in Graduate Education this coming year, as there is bound to be a great need for such activities. The infusion of new blood into the committee would seem distinctly advisable.

Respectfully submitted,

FREDERICK T. HILL, M. D.,
Chairman, Committee on Graduate Education.

Committee to Survey Hospital and Medical Care

A full report of the work of this Committee, together with the reasons for recommending consideration by the Association of the Massachusetts Plan for Medical Care, will be presented to the House of Delegates at the June meeting.

S. J. BEACH, M. D.,
Chairman, Committee to Survey Hospital and Medical Care.

Committee for Conservation of Vision

To the Officers and Members of the Maine Medical Association:

Your committee has not been idle. We have had two meetings during the year and have started a program hoping to acquaint the profession at large with the seriousness of the glaucoma problem in particular.

This is definitely a long arranged program and it is suggested that the same committee be continued.

Respectfully submitted,

W. E. KERSHNER, M. D.,
Chairman, Committee for Conservation of Vision.

Have You Made Your Reservations

for the

Annual Meeting?

Report of the Secretary

To the Officers and Members of the Maine Medical Association:

As your Secretary I am pleased to submit the following report:

There are 730 members in good standing in the Association; 515 Active, 186 in Military Service, and 29 Honorary. Ten new members have been added to the roster during the past year, and two were re-instated to membership. We have lost eighteen members by death and five have moved out of the State.

100% payment of dues has been received from ten county societies.

The program for the 91st Annual Session appears elsewhere in this issue, and a résumé of it in the Editorial.

I wish to express my appreciation to the County Secretaries, Councilors, and Officers of the Association, for their coöperation during the past year. Also to those members in Military Service, now serving on many fronts, who we hope will be back again to resume their practice in a world at peace before another annual session, and to the members who are so valiantly serving on the home front, and whose coöperation has helped make this a successful year in the history of the Association.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary.

May 31, 1944.

Report of the Treasurer

To the Officers and Members of the Maine Medical Association:

As your Treasurer I wish to make the following report:

It has been impossible, because of existing conditions, for Jordan and Jordan, Accountants and Auditors, to audit the books of the Association and "Journal" in time to publish a report in this issue of the "Journal." I can, however, state that the financial standing of the Association and "Journal" is sound and that a complete report, as prepared by Jordan and Jordan, will be sent to the members of the Financial Advisory Committee early in June, and will be presented at the First Meeting of the House of Delegates on Sunday, June 25th, at 4.30 P. M., and published in the July issue of the "Journal." A copy will also be on file in the Portland office where it will be available to any member of the Association.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Treasurer.

May 31, 1944.

In Memoriam

Members Deceased since May 31, 1943

Abbott, Edward S.,	Bridgton
Bates, George F.,	Portland
Bean, Johnson L.,	Norway
Binford, Horace J.,	Mexico
Clason, Silas O.,	Gardiner
Cook, Edward M.,	York Harbor
Currier, Everett B.,	Phillips
Fernald, Henry E.,	East Boothbay
Hunt, Charles H.,	Portland
Milliken, John S.,	Portland
Mitchell, Frederick W.,	Houlton
Nutting, James D.,	Hallowell
Oram, Julius C.,	South Portland
Phillips, Robert T.,	Portland
Smith, Harry W.,	Norridgewock
Smith, Owen,	Portland
Staples, Ivan,	Norway
Woodman, George M.,	Westbrook

Program

91st ANNUAL SESSION
MAINE MEDICAL ASSOCIATION

JUNE 25, 26, 27, 1944

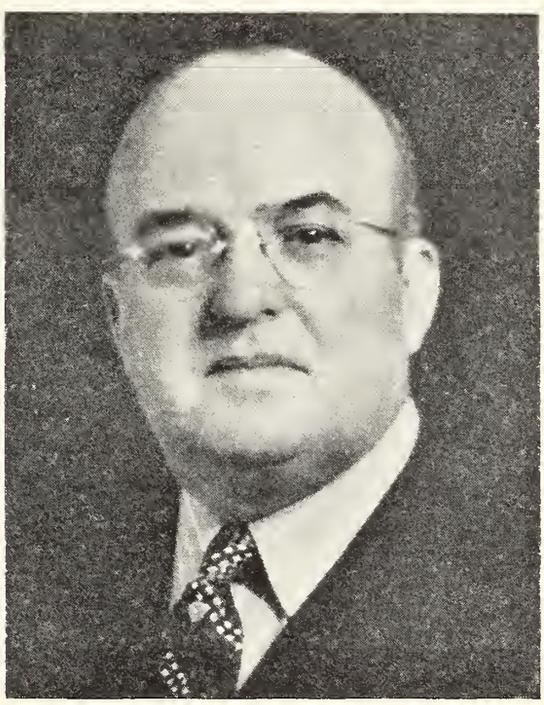
THE SAMOSET

ROCKLAND, MAINE

PROGRAM ARRANGED

BY THE

SCIENTIFIC COMMITTEE



ROLAND L. McKAY

Chairman

INFORMATION

Registration:

Registration headquarters will be in the Lobby of The Sam O set. Every member and guest is requested to register and receive a badge on arrival.

Emergency Calls:

All emergency calls will be given prompt attention. Leave your name with the Association registrar if expecting any calls.

Motor Travel to the Meeting:

See Correspondence from the Office of Price Administration, Augusta, Maine, in the April issue of the "Journal," page 74.

Papers:

All papers read before this Association shall be its property for publication in "The Journal of the Maine Medical Association," and when read shall be deposited with the Secretary.

RECEPTION COMMITTEE

Thomas A. Foster, M. D., Portland
George F. Pratt, M. D., Farmington
Frank A. Smith, M. D., Westbrook
C. Harold Jameson, M. D., Rockland
Carl M. Robinson, M. D., Portland
Leon D. Herring, M. D., Winthrop
Frederick T. Hill, M. D., Waterville
William Holt, M. D., Portland

SUNDAY, JUNE 25, 1944

4.30 P. M.

First Meeting of the House of Delegates.

7.00 P. M.

Dinner.

8.30 P. M.

Guest Speaker, **Morris Fishbein, M. D., Editor, "The Journal of the American Medical Association."**

Subject: Changes in Medical Practice and the Wagner-Murray-Dingell Bill.

MONDAY, JUNE 26, 1944

Morning Session

9.00-9.30 A. M.

General Assembly:

President Oscar F. Larson, M. D., presiding

Invocation:

Rev. John Smith Lowe, Pastor of First Universalist Church, Rockland

Announcements:

Roland L. McKay, M. D., Chairman, Scientific Committee
Frederick R. Carter, M. D., Secretary

9.30 A. M.-12.00 M.

Conferences

I

TRAUMATIC SURGERY

Chairman: Morris E. Goldman, M. D., Lewiston

1. Injuries in and about the Knee Joint,
   Jurgens H. Bauer, M. D., Boston City Hospital, Boston
2. Mechanism of Chest Injuries,
   George E. Young, M. D., Skowhegan
3. Head Injuries,
   H. Eugene MacDonald, M. D., Portland
4. Hip Fractures,
   Maurice E. Goldman, M. D., Lewiston

II

OBSTETRICAL AND GYNECOLOGICAL

Chairman: Magnus Ridlon, M. D., Bangor

Informal Discussion.

III

THORACIC SURGERY AND PULMONARY INFECTION

Chairman: George E. Young, M. D., Skowhegan

1. Types of Pulmonary Tuberculosis (Presenting Cases),
   Lester Adams, M. D., Hebron
2. Bronchial Studies and Their Aid in Differential Diagnosis,
   Frederick T. Hill, M. D., Waterville
3. Presenting an Interesting Pulmonary Case,
   Chakmakis James, M. D., Lewiston
4. Pulmonary Problems, especially those Presented by Supposed Virus Infections,
   George E. Young, M. D., Skowhegan

IV

OTO-LARYNGOLOGY

Chairman: Henry P. Johnson, M. D., Portland

1. Allergis Rhinitis,
   Benjamin Zolov, M. D., Portland
2. Hoarseness,
   Frederick T. Hill, M. D., Waterville
3. Headaches of Nasal Origin,
   William H. Chaffers, M. D., Lewiston

Luncheon

12.30 P. M.

Tables will be reserved for reunions of alumni of Boston University, Johns Hopkins, Bowdoin, McGill, Vermont, Tufts, Yale and Harvard Medical Schools, and members of the Tumor Clinics.

Afternoon Session

1.45-4.45 P. M.

SCIENTIFIC SESSION

1. Introduction of Visiting Delegates.

2. Post-War Problem—Providing Adequate Opportunities for Graduate Medical Education,
Malcolm T. MacEachern, M. D., Chicago, Associate Director, American College of Surgeons

3. The Great Advances in the Understanding and Treatment of Heart Disease During the Past Twenty-five Years,
Paul Dudley White, M. D., Boston, Mass.

4. Vascular Diseases and Anti-Coagulants,
Joseph E. Doane, M. D., Professor of Clinical Education, Temple University, Philadelphia

5. The Significance of the Rh Factor in Blood,
Joseph E. Porter, M. D., Associate Pathologist, Maine General Hospital, Portland, Me.

5.00 P. M.

Election of President-elect.

5.30 P. M.

Second Meeting of the House of Delegates.

Evening Session
7.00 P. M.

Dinner.

Guest Speaker, **Frank H. Lahey, M. D., Boston, Mass.**

Subject: The Management of the Surgical Lesions of the Terminal Ileum, Colon and Rectum.

President's Reception.

Dancing.

TUESDAY, JUNE 27, 1944

Morning Session
9.00 A. M.-12.00 M.

Conferences

I

Annual Meeting of the Maine Medico-Legal Society

President: D. M. Stewart, M. D., South Paris, presiding

Program

Reports of Officers.

Election of Officers for ensuing year.

W. W. Watters, M. D., Boston, Suffolk County Medical Examiner, will tell about the last and the next institutes for Medical Examiners, County Attorneys and Police Officials, held in Boston.

Arch H. Morrell, M. D., of Augusta, will present an interesting case with one of the Medical Examiners.

Chief Justice, Guy H. Sturgis, of Portland, will address the meeting.

George L. Pratt, M. D.,
Secretary.

II

Surgery

Chairman: James M. Parker., M. D., Portland

1. Problems of Acute G. I. Hemorrhage,
E. H. Risley, M. D., Waterville

2. Some Aids in Abdominal Surgery,
C. M. Robinson, M. D., Portland

3. Surgery of the Gall Bladder and Bile Ducts,
E. L. Herlihy, M. D., Bangor

4. Some X-ray and Clinical Aspects of Intestinal Obstruction,
I. M. Webber, M. D., Portland

5. The Phlebo-Embolic Problem and Femoral Ligation,
J. M. Parker, M. D., Portland

III

Fractures

Chairman: Allan Woodcock, M. D., Bangor

Informal Discussion.

Those who have cases to present or discuss should bring X-ray plates.

IV

Medicine

Chairman: John O. Piper, M. D., Waterville

1. Use of Sulfa in Eye Work,
Howard F. Hill, M. D., Waterville

2. Use of Sulfa in the Upper Respiratory Tract,
Frederick T. Hill, M. D., Waterville

3. Use of Sulfa in Gynecology and Obstetrics,
A. H. McQuillan, M. D., Waterville

4. Use of Sulfa in General Medicine,
John O. Piper, M. D., Waterville

5. Use of Sulfa in General Surgery, More Especially Urology,
C. Harold Jameson, M. D., Rockland

Luncheon
12.30 P. M.

Tables will be reserved for Past Presidents and County Secretaries.

Afternoon Session
1.45-5.00 P. M.

Scientific Session

1. President's Address,
Oscar F. Larson, M. D., Machias

2. (Subject to be announced),
Thomas Parran, M. D., Surgeon General, U. S. Public Health Service

3. Recent Developments in the Treatment of War Casualties,
D. W. Lyon, Captain (MC) U. S. N., Executive Officer, U. S. Naval Hospital, Portsmouth, N. H.

4. War Neuroses,
Medical officer to be Assigned from U. S. Army Medical Corps

5. A Medical Metamorphosis,
Adam P. Leighton, M. D., Portland

Evening Session

7.00 P. M.

Annual Dinner (Dress Optional).

Guest Speaker: (To be announced.)

Presentation of Fifty-Year Medals by President Oscar F. Larson, M. D.

Special Notices

Fifty-Year Service Medals

Fifty-Year Service Medals will be presented at the dinner Tuesday evening to the following members:

Androscoggin County Medical Association

Albert W. Plummer, M. D., Lisbon Falls, Bowdoin, 1894.

Cumberland County Medical Association

Harvey Howard, M. D., Freeport, Rush Medical College, 1894.

John L. Pepper, M. D., South Portland, Bowdoin, 1894.

Penobscot County Medical Association

J. Albert Lethiecq, M. D., Brewer, Jefferson Medical College, 1894.

Eugene B. Sanger, M. D., Bangor, Columbia University College of Physicians and Surgeons, 1894.

York County Medical Society

William E. Lightle, M. D., North Berwick, Baltimore Medical College, 1894.

William W. Smith, M. D., Ogunquit, Dartmouth Medical College, 1894.

Arthur J. Stimpson, M. D., Kennebunk, Bowdoin, 1894.

Sixty Years in Practice

J. S. Sturtevant, M. D., of Dixfield, who graduated from Bowdoin Medical School in 1884, and received the Fifty Year Medal in June, 1934, will be presented with a ten-year service bar denoting sixty years in the practice of medicine, at the dinner Tuesday evening.

Golf Tournament

The Association will hold its Sixth Annual Golf Tournament on the Sam O set Golf Course.

It will be conducted by Forrest C. Tyson, M. D., of Augusta.

Prizes will be awarded to the winners.

Program for the Ladies

Registration

Entertainment Committee:

Mrs. Oscar F. Larson, Machias
Mrs. C. Harold Jameson, Rockland
Mrs. R. L. McKay, Augusta

Monday, June 26:

Afternoon—Tea
Evening—Reading by Miss Barbara Dwinal

Tuesday, June 27:

Tournament, Auction and Contract

Convention Rates 1944 Annual Session

Sam O set Hotel, Rockland, Maine June 25, 26, 27, 1944

$9.00 a day per person. This rate includes all extras, with the exception of golf for which a special rate of one dollar a day is offered.

The Sam O set offers everything in the line of recreation and sport; a golf course, heated salt-water swimming pool, tennis courts, and badminton.

Official Delegates, 1944

State Medical Societies

The Massachusetts Medical Society

Warren H. Sherman, M. D., 9 Central Street, Lowell.

Frank W. Snow, M. D., 24 Essex Street, Newburyport.

The Connecticut State Medical Society

Stanley B. Weld, M. D., 179 Allyn Street, Hartford.

Orville F. Rogers, M. D., 109 College Street, New Haven.

Rhode Island Medical Society

Henry B. Moor, M. D., 147 Angell Street, Providence.

Jay Perkins, M. D., Stockton Springs, Maine.

County Medical Societies

FIRST DISTRICT

Cumberland County

Delegates: (One Year)
C. Earle Richardson, M. D., Brunswick.
Richard S. Hawkes, M. D., Portland.
William Holt, M. D., Portland.
Benjamin Zolov, M. D., Portland.

(Two Years):
Oscar R. Johnson, M. D., Portland.
Joseph E. Porter, M. D., Portland.
Louis L. Hills, M. D., Westbrook.

Alternates: (One Year)
Isaac M. Webber, M. D., Portland.
Harlan R. Whitney, M. D., Portland.

(Two Years):
Theodore C. Bramhall, M. D., Portland.
Harold V. Bickmore, M. D., Portland.

York County

Delegates:
Edward M. Cook, M. D., York Harbor.
James H. MacDonald, M. D., Kennebunk.
Charles W. Kinghorn, M. D., Kittery.

Alternates:
William H. Kelly, M. D., Sanford.
Oscar Perrault, M. D., Biddeford.

SECOND DISTRICT

Androscoggin County

Delegates:
Ralph A. Goodwin, M. D., Auburn.
Horace L. Gauvreau, M. D., Lewiston.
William H. Chaffers, M. D., Lewiston.

Alternates:
Albert W. Plummer, M. D., Lisbon Falls.
Blinn W. Russell, M. D., Leeds.
Paul R. Chevalier, M. D., Lewiston.

Franklin County

Delegate:
George L. Pratt, M. D., Farmington.

Alternate:
Cecil F. Thompson, M. D., Phillips.

Oxford County

Delegates:
Harold W. Stanwood, M. D., Rumford.
Garfield G. Defoe, M. D., Dixfield.

Alternates:
Walter G. Dixon, M. D., Norway.
Albert P. Royal, M. D., Rumford.

THIRD DISTRICT

Knox County

Delegates:
C. Harold Jameson, M. D., Rockland.
James Carswell, Jr., M. D., Camden.

Alternates:
Herman J. Weisman, Rockland.
Abbott J. Fuller, M. D., Pemaquid.

Lincoln-Sagadahoc Counties

Delegate:
James W. Laughlin, M. D., Newcastle.

Alternate:
Warren E. Kershner, M. D., Bath.

FOURTH DISTRICT

Kennebec County

Delegates:
Ivan E. McLaughlin, M. D., Gardiner.
Frank B. Bull, M. D., Gardiner.
L. Armand Guite, M. D., Waterville.
Adolphe J. Gingras, M. D., Augusta.

Somerset County

Delegate:
Walter S. Stinchfield, M. D., Skowhegan.

Alternate:
Maurice S. Philbrick, M. D., Skowhegan.

Waldo County

Delegate:
Carl H. Stevens, M. D., Belfast.

Alternate:
Seth H. Read, M. D., Belfast.

FIFTH DISTRICT

Hancock County

Delegate:
Edward Thegan, M. D., Bucksport.

Alternate:
Hyman Millstein, M. D., Southwest Harbor.

Washington County

Delegate:
Willard H. Bunker, M. D., Calais.

Alternate:
DaCosta F. Bennett, M. D., Lubec.

SIXTH DISTRICT

Aroostook County

Delegates:
Francois J. Faucher, M. D., Grand Isle.
Clyde I. Swett, M. D., Island Falls.

Alternates:
Joseph H. Albert, M. D., Fort Kent.
Herrick C. Kimball, M. D., Fort Fairfield.

Penobscot County

Delegates:

LeRoy H. Smith, M. D., Winterport.
Samuel S. Silsby, M. D., Bangor.
Frank D. Weymouth, M. D., Brewer.
Ernest T. Young, M. D., Millinocket.

Alternates:

Hugh G. McKay, M. D., Old Town.
Carl E. Blaisdell, M. D., Bangor.
Asa C. Adams, M. D., Orono.

Piscataquis County

Delegate:

Fred J. Pritham, M. D., Greenville Junction.

Alternate:

Ralph C. Stuart, M. D., Guilford.

Association Delegates to 1944 Annual Sessions

American Medical Association
Thomas A. Foster, M. D., Portland.

The Connecticut State Medical Society
Oscar R. Johnson, M. D., Portland.

The Massachusetts Medical Society
Martyn A. Vickers, M. D., Bangor.

The New Hampshire Medical Society
Charles W. Kinghorn, M. D., Kittery.

Rhode Island Medical Society
Joseph E. Porter, M. D., Portland.

Commercial Exhibits, Ninety-first Annual Session

Elmer N. Blackwell, 207 Strand Building, Portland, Maine.

Surgical Appliances.

Today's increase in industrial injuries and body strains demand aid and protection to enable men and women to continue working. BLACKWELL'S offer the profession a complete line of supports for industrial workers and also corrective appliances for all other cases needing bodily aids.

Nineteen years of specialization in making and fitting all types of Abdominal and Back Supports, Trusses, Arches, Corsets, Elastic Hosiery, and Braces, assure the doctors of getting the best available service for every patient.

Prompt mail order service or immediate fittings to all patients, has always been an outstanding factor in doing business with BLACKWELL'S.

The Borden Company, 350 Madison Avenue, New York City.

Visit the Borden Booth and learn about our special-purpose infant foods of unsurpassed quality. Biolac, the distinctive new *liquid* infant food, affording convenience, economy, and optimal nutrition is now packaged in the new 13-ounce wartime tin. Stop by for complete feeding directions! New Improved Dryco affords quicker solubility, lower cost, and increased vitamin potencies. It still retains all the unique digestional and nutritional advantages of the original Dryco. Mull-Soy, the emulsified soy bean food for infants, children and adults allergic to milk. Borden's Beta Lactose is *nature's* carbohydrate in an improved, readily soluble form. Klim and Merrell-Soule Milk Powders also will be displayed.

Brewer & Company, Inc., 12 East Worcester Street, Worcester, Massachusetts.

"BREWER & COMPANY, INC., Worcester, Massachusetts, will feature Ether-in-Oil Ampuls used in the treatment of bronchial asthma. Another product is vitamin D ampuls of 400,000 units, called Hi-Deratol, which many physicians are using to supplement their medication in the treatment of calcium and phosphorus metabolism upsets. Incidentally, Hi-Deratol ampuls are noted for their high potency of vitamin D. Our representatives will be glad to discuss with physicians the merits of other Brewer products, such as Thesodate, Luasmin, EnKIde, etc."

The Coca-Cola Company, Atlanta, Georgia—The Coca-Cola Bottling Plants, Inc., South Portland, Maine.

"Coca-Cola" will be served to the members and guests with the compliments of The Coca-Cola Company.

The Doho Chemical Corporation, 58 Varick Street, New York City.

Animated Pathological Ear Exhibit.

The Auralgan Exhibit consists of a model of the human auricle four feet high together with a series of twenty-four three dimensional ear drums, modelled under the supervision of outstanding otologists. Each of these drums depict a different pathologic condition based upon actual case observation and prepared, in so far as possible, with strict scientific accuracy so as to be highly instructive and interesting to all physicians.

F. A. Davis Company, 1914-1916 Cherry Street, Philadelphia.

At our booth you will find exhibited many new medical books and new editions. To mention a few: Stroud Cardiology, Reimann Treatment, Goldzieher Adrenals, Smith Sulfonamide Therapy, Litchfield-Dembo Therapeutics of Infancy and Childhood, Loewenberg Medical Diagnosis, Gordon, The Romance of Medicine, Kennedy-Campbell Vaginal Hysterectomy and others. And by all means examine the CYCLOPEDIA OF MEDICINE, SURGERY and SPECIALTIES—a complete reference library in one unit, covering all problems confronting the busy doctor and giving authoritative practical answers speedily. Most complete and accessible work of its kind—saves time. Always up to date and stresses treatment. Special convention proposition.

Phospho-Soda (Fleet). The C. B. Fleet Co., Inc., Lynchburg, Virginia.

Many physicians take advantage of our brief annual call and our attendance at conventions for two purposes:

1. To be reminded of such fundamental, but easily forgotten facts as the biliary, buffer and intestinal cleansing action of Phospho-Soda (Fleet). This helps them in their daily prescribing.

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Since our ability to detail Phospho-Soda (Fleet) is so sharply limited in these times, please use us generously at your convention for these and any other purposes.

Geo. C. Frye Co., 116 Free Street, Portland, Maine.

We welcome the opportunity of again participating in the annual meeting of the Maine Medical Association. We will have on display furniture and equipment which is now available for use in the physician's office. There will also be shown new instruments, diagnostic equipment, and supplies of interest to the general practitioner, obstetrician, urologist, and physician.

We cordially invite you to visit us during the convention and discuss your requirements. Since the lifting of many of the War Production Board restrictions, it is now possible to obtain many items of equipment which were previously not available.

Maine Surgical Supply Co., 10 Longfellow Square, Portland, Maine.

The Maine Surgical Supply Company, who are now enjoying their fifth year of service to Maine Physicians as well as Hospitals extends to one and all, an invitation to visit their exhibit.

They mention that they will make every effort to have an interesting exhibit.

Due to the fact that their salesman, Ernest M. Niles is now serving in the U. S. Navy as Chief Pharmacist Mate, the Proprietor John Lacy will be in attendance and will make every effort to welcome you to the 1944 convention.

E. F. Mahady Company, 851-857 Boylston Street, Boston, Mass.

Hospital and Medical Supplies—Scientific Instruments—Medical and Nursing Books.

Mead Johnson & Co., Evansville, Indiana.

"Servamus Fidem" means We Are Keeping the Faith. Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum, and other infant diet materials—including the new pre-cooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive company offers physicians. A visit to our Booth will be time well spent.

Philip Morris & Co., Ltd., 119 Fifth Avenue, New York City.

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

The P. J. Noyes Company, Lancaster, New Hampshire.

We are grateful for the opportunity of contributing in a modest way towards the success of the meeting of the Maine Medical Association. Joe E. Brown, Representative.

Poloris Company, Inc., 12 High Street, Jersey City, New Jersey.

The Poloris Company's exhibit will feature an interesting display of the medicinal ingredients contained in Poloris Dental Poultice.

This display has been designed to acquaint the members of the medical profession with the purpose of Poloris Dental Poultice, namely, local medicinal counter-irritation for the prompt emergency relief of irritation, inflammation or congestion of the teeth and gums. Members and their guests are cordially invited to visit the Poloris exhibit.

R. J. Strasenburgh Co., Rochester, New York.

The feature of this exhibit will be a demonstration of the safe non-toxic spasmolytic action obtained with METROPINE (Methyl Atropine Nitrate, Strasenburgh).

A. Metropine has only 1/10th the mydriatic action and 1/50th the toxicity of Atropine.

B. Absence of the undesirable side reactions often observed with Atropine is assured.

Surgeons' & Physicians' Supply Co., 761 Boylston Street, Boston, Massachusetts.

The Surgeons' & Physicians' Supply Company will exhibit a number of new and interesting products, including the Wyeth Allergy Test Set, using the Bartos System.

White Laboratories, Inc., 113 North 13th Street, Newark, New Jersey.

At the WHITE LABORATORIES' Booth you will find interesting copies of a series of publications under the general title "Diagnostic Aids To Vitamin Deficiency Conditions." Medical Service Representatives in attendance will be very glad to discuss these with you. The latest clinical reports on results of the use of White's Vitamin A and D Ointment in the treatment of burns and various types of ulcers will also be available. This is a product which you will undoubtedly find of great interest.

Wyeth Incorporated, 1600 Arch Street, Philadelphia.

You are invited to visit the Petrogalar Laboratories Booth where our representative will be pleased to suggest new uses for Petrogalar in your practice.

Literature and samples may be had for the asking.

Petrogalar Laboratories, Inc.
Division

You are cordially invited to visit the Wyeth exhibit where Amphojel, Phosphaljel, Bepron and B-Plex will be featured and other Pharmaceutical specialties.

John Wyeth and Brother
Division

Up-to-the-minute information on *Infant Feeding and Nutritional Biochemicals* can be obtained at the S. M. A. Corporation Booth.

Of particular interest to most physicians is the new protected Vitamin A product *Caritol.*

S. M. A. Corporation
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Maternal and Child Welfare
Continued from page 112

For the family of the soldier the E. M. I. C. program provides maternity care and care of the infant up to one year, good care without luxuries. A standard is set up which will protect the patient and improve medical practice. The family must clearly understand, however, that the program is limited to these two items. Maternity care does not include house visits for trivia nor are older children included in the program. The doctor is definitely not at the patient's beck and call. The patient may not supplement the Government funds to obtain luxuries, private nurses, etc. When a physician accepts a patient under this program he should carefully explain these things to her.

The physician under this program is obligated to give good maternity and infant care and keep adequate records as he must send in a properly rendered report with his bill. Coöperation by the physician will improve maternity care in this State.

YOUR COMMITTEE ON MATERNAL AND CHILD WELFARE.

Since the above article was filed additional information has come from Augusta which affects the fees quoted above. The fee for a Caesarean section will probably be $45.00 after July 1st, but this is not entirely settled. The fee for prenatal care will be $15.00 for seven prenatal examinations. These examinations must be really complete and include a Kahn Test. There is a provision for immunization of children for smallpox, diphtheria, and pertussis. The fee is $6.00 which includes all three immunizations. The material will be supplied through the Maternal and Child Health Division.

ALBERT W. FELLOWS, M. D.,
Chairman.

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MAY 31, 1944

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Book Reviews—Continued from page 114

"Synopsis of Diseases of the Heart and Arteries"

By: George R. Herrmann, M. S., M. D., Ph. D., F. A. C. P. Professor of Medicine, University of Texas. Director of the Cardiovascular Service, John Sealey Hospital; Consultant in Vascular Diseases, U. S. Marine Hospital.

Third Edition with 103 text illustrations and 4 color plates.

Published by The C. V. Mosby Company, St. Louis, 1944. Price, $5.00.

Completely revised and with several new chapters added, Dr. George R. Herrmann has penned a third edition of his 1936 and 1941 discussions of diseases of the heart and arteries. The earlier editions, which met a popular fancy among medical men at the time, seem a bit outdated with the appearance of this third edition. In the three years since the second edition, Dr. Herrmann devoted valuable time to research and study to the end that his newest endeavor adds chapters on Nervous Disorders with Cardiac Manifestations, Blood Pressure Abnormalities, Essential Hypertension and General Systemic Types of Heart Disease. An appendix on the new data derived from unipolar central terminal precordial leads has been added. The addition of new diagrams and the advent of war medical literature make the third edition outstanding among Dr. Herrmann's literary efforts.

"Synopsis of Neuropsychiatry"

By: Lowell S. Selling, Sc. M., M. D., Ph. D., Dr. P. H. Director, Psychopathic Clinic, Recorder's Court, Detroit, Michigan; Associate Attending Neuropsychiatrist, Eloise Hospital; Adjunct Attending Neuropsychiatrist, Harper Hospital.

Published by The C. V. Mosby Company, St. Louis, 1944. Price, $5.00.

Virtually a whole medical school of knowledge and information on mental and neurological diseases are contained in the compact 473 pages which comprise Dr. Seller's Synopsis of Neuropsychiatry. Not only will the specialist find this publication the answer to a need of long standing, but the general practitioner will do well to add this volume to his library shelf. The book itself is actually a standardized guide and does away with the necessity of conventional medical textbooks. Brief, yet conclusive discussions of interest and concern to the neurologist and psychiatrist are offered. The publication meets a modern need in that at the conclusion of each chapter is a discussion reflecting the manner in which a given disease affects the military and medicolegal status of the individual. Another chapter of interest and value is that dealing with the behavior habits of children.

"Industrial Ophthalmology"

By: Hedwig S. Kuhn, M. D., Hammond, Indiana.

With 114 text illustrations, including 2 color plates.

Published by The C. V. Mosby Company, St. Louis, 1944. Price, $6.50.

Industrial ophthalmology takes on a new meaning as Dr. Kuhn, associated with the Department of Industrial Psychology at Purdue University, delves into the need of perfect eyesight as it relates to the war effort. She points out that special visual skills are more essential today than at any time in the Nation's long history, yet neither industry nor the medical profession has been able to devise the answer to many eye problems of the war worker. Coming from an industrial city, Dr. Kuhn makes this book a backlog of medical facts and actual conditions as she found them in constant visits to industrial plants. Of considerable interest is her discussion of proper goggles for welders and others, and the problems of radiation, welding and "flashes." Medically and industrially, the publication answers many everyday questions as she makes this an interesting and comprehensive exposition of industrial ophthalmology.

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of the
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*Presidential Address**

Oscar F. Larson, M. D., Machias, Maine

I am deeply appreciative of the honor which gives me the opportunity to welcome you today to the 91st annual meeting of the Maine Medical Association.

I wish at this time to express my appreciation for the help and guidance that our efficient Secretary and Editor of our Journal, Dr. Frederick R. Carter, has given me, ably assisted by Mrs. Kennard.

The members of our Council, individually and collectively, under the leadership of Dr. Piper, have rendered yeoman's service under trying circumstances, and should have our thanks for a task well done.

The various committees appointed at the beginning of our fiscal year, have all functioned well. The members of some of these committees have spent much of their valuable time in the performance of their duty, and every President realizes that there are a number of men about our State who have the affairs of our Association uppermost in their minds, men who can be called upon for aid and advice, these are the Past Presidents who are still active in Association affairs; and let us not forget that able guardian of the portals of our Sanctum Sanctorum, Dr. Adam Leighton.

Herbert E. Locke, our honorary member and legal advisor, is always ready to smooth our wrinkled brows and steer our craft through the deeper channels. This year a new star has appeared above the horizon, to whom I think the accolade for a meritorious performance should be given. I refer to Dr. Roland Lee McKay, who almost single handed prepared and saw carried out, this 3-day program.

I wish to express the thanks of the Association and my own grateful appreciation to our distinguished guests who have spent so much of their time and energy in responding to our invitation and have added, and are adding, so much of value to this program.

I deeply and sincerely regret the absence of those members who are now with the armed forces of our country. At the same time I wish in behalf of the Maine Medical Association to express my highest commendation of their loyalty and devotion to our country in these momentous days.

Having been a country practitioner for nearly 40 years in a region of our State, where drives of from 20 to 35 miles are not infrequent, ample opportunity has been given me for

* Presented at the 91st Annual Session of the Maine Medical Association, at Rockland, Maine, June 27, 1944.

thought and reflection concerning ancient Medical history, into which I occasionally delve. Archaeologists and writers of ancient history tell us that at least half a million years ago man began an endless struggle against disease; that the first implement in the hands of the neolithic surgeon was a flint, and that trephinning the skull for the release of demons was the earliest operation of which any evidence remains. The earliest so-called practice of medicine was a mixture of superstition and mysticism. In fact, medicine, religion and magic have marched down the centuries hand in hand. The original founders of the medical art, of which there is any authentic record, were philosophers as well as physicians, and to them should be given the credit of rescuing medical practice from sorcery and superstition. To Hippocrates, renowned Greek physician, born 460 B. C. and known as the Father of Medicine, can be credited the basis for our present Medical ethics in the form of the "Hippocratic Oath." Hippocrates was a prolific writer. Many of his beliefs have been handed down to us. Perhaps one of the better known facts, which holds true today, is that the diagnosis of disease depends primarily on the observation and notation of symptoms.

Claudius Galen, anatomist and physiologist, lived about 500 years after Hippocrates; from his many writings other truths have been handed down to us, but except for Rhages, the great Arabian physician and a few men connected with the Medical school founded at Salerno, Italy, about 900 A. D., no further advance was made in medicine until the birth in 1500 A. D. of that Great Triumvirate, Paracelsus, the Scientist; Versalius, the Anatomist; and Pare, the Surgeon. In more recent times, the names Pasteur, Harvey and Lister, with their revolutionary discoveries, will always occupy a prominent place in the Medical Hall of Fame. These men were the real founders of Modern Medicine, but not of course, the modern medical science as we know it today, with its great laboratories and clinics. When we realize under what great difficulties these patient men labored, how much greater then should be our appreciation of their work. In our own country, the names of McDowell, Long, Sims, and many others are still fresh in our memories.

The transition from the covered wagon of the forty-niners, to the air flights across our continents, have annihilated time and space. We travel through mountains and under rivers; we cross the ocean in a day. Man, during the last century seems to have conquered almost everything except the elements and disease. The greatest problem of the ages is the prevention and curing of the diseases to which man is subject. How well the American Physician has responded to this call of humanity is exemplified by the fact that typhoid fever and diphtheria are practically eradicated; that yellow fever, which as late as the eighteen eighties, was the cause of thousands of deaths in this country alone, is now rarely heard of. A wonderful start has been made, and with the philosophy of the ancients to guide our footsteps, along with the knowledge opened up by Masters of Medical Science, greater progress may be expected as time passes and research marches on.

Today, the practice of medicine is at the cross roads. Let us not forget that our profession is an honorable one, and that whatever betides us, our banner must remain unsullied. Furthermore, let us not forget that the private practice of medicine is *not* a divine right. It is rather a privilege granted by Society. The urgent necessity for formulation of a national medical care program should not be stultified by confusion over secondary issues. We must offer to the American people a socially intelligent medical care program, that will safeguard private enterprise; be free from regimentation and bureaucratic control, and at the same time, accomplish what millions of our people now demand, viz: a means of taking care of the various emergencies that arise throughout life, due to sickness and injury. Such a plan can be achieved only by honest, professional realism supported by an informed public opinion. To obtain an informed *expression* of public opinion, the people must be acquainted with the scientific, social and economic aspects of medical progress in these United States. This task will fall far short of its goal unless aggressive action is taken by organized medicine.

Our foes are numerous, powerful and resourceful. The struggle is unending, and will at times, seem hardly worth the candle, but the

Continued on page 138

Infectious Venereal Diseases

Paul R. Briggs, M. D., Hartland, Maine

When the world is at war, the practitioner left at home should be vigilant in his association with infectious venereal diseases.

Pathology that is uncommon in one section of the country is a potential menace to a community if the physician is not on the alert for the unusual and does not have at least a working knowledge of how to recognize a venereal infection and to treat the same with an acceptable degree of fortitude.

The rapid means of transportation and the various contacts in and around military camps and shipyards are the main causes of this menace together with the male shortage in the local community.

Neisser Infection has been on the up-grade as to frequency regardless of the use of sulpha drugs to which it apparently responds nicely in most of our cases. This, of course, is caused by the gonococcus which can easily be demonstrated by a smear. It shows itself as a urethritis, prostatitis, vesiculitis, and even as arthritis in the male. In the female as a vaginitis, salpingitis or arthritis. The sulpha drugs as heretofore mentioned is the medication of choice with or without local therapy.

Syphilis in the primary or secondary stages has been a rarity to the average practitioner — today it is a commonplace.

How shall this disease be recognized? The primary lesion is a "hard sore" for the most part and is usually called the chancre. This occurs from two to four weeks after suspicious coitus. It is rarely large but feels hard to the examining fingers. The patient usually has no pain. It is highly contagious. Secondary lesions present a series of erosions, flat condylomata, a body eruption, a sore mouth and throat or combination of any or all.

Wassermann Tests may be negative in the primary stages but are usually positive in the secondary type. Darkfield examination, if possible, should be carried out and the causative factor may be early elicited.

The treatment of primary and secondary lues is still based on arsenicals and the heavy metals. These, if started early, usually result in an early cure.

Chancroid, an infectious ulcer, although rare in many parts of the United States is now showing itself in the remote villages as a direct result of this war. This has been described as the "soft chancre" and appears as an ulcer usually on or about the genitals. It is a painful lesion and develops two to seven days after coitus as a small pustule. The pustule rapidly breaks down to form an ulcer. Oftentimes the ulcer formation is multiple indicating autoinoculation. There is occasionally an adenitis in one or both groins which may go on to suppuration.

Serum secured with an aspirator before pus formation shows the Ducrey Bacillus as does oftentimes culture and smear from the discharging ulcer. Treatment of this condition has swung from radical extirpation and cautery to the use of sulphonamides locally and systemically which result in a rapid cure. Arsenicals and heavy metals have no effect on healing these lesions.

Granuloma Inquinale or venereal granuloma is of frequent occurrence in the South and should always be borne in mind when one sees an ulcer on or about the genitals discharging a foul thick material. These people also complain of pain and usually admit promiscuous sexual intercourse of approximately one month before the lesion appears. Darkfield examination is negative—there are no Ducrey Bacilli but Donovan bodies are usually found in a fresh smear. Tarter emetic or Fouadin result in a rapid cure.

Lymphogranuloma Inquinale is a disease of tropical frequence and occurs on approximately the same areas of the body as Granuloma Inquinale. This is a disease characterized by adenitis of the inquinale region, ulceration in various regions in and around the genitals. It is a condition caused by a filterable virus and is purely a disease of the lymph channels and nodes which frequently break down to ulceration. Tarter Emetic and arsenicals have no effect. The Frei test is usually its only positive identification.

Sulphonamides are recently being used with success in this dread condition which previously was subject to surgery, cautery, X-ray and various vaccines.

The federal armed forces are coöperating with our public health service in reporting contacts of all venereal infections and are to be commended for this effort.

The author as a practitioner in a small country town has had four cases of primary lues, seven cases of gonorrhea, and one case of chancroid in the course of one month directly attributal to contacts from and near army camps and shipyards.

Case I. A fourteen-year-old female, confined at home for six weeks with "gas" in bowels, was seen in early January. History showed her "boy friend" was home on furlough two weeks previous to her illness and at that time had difficulty with a urethral discharge. Pain in abdomen, leukorrhea and fever were the chief complaints of the female. Diagnosis of salpingitis was confirmed by smear. Sulpha drugs were given together with diathermy and patient was up about and at school in one week.

Case II. A twenty-one-year-old woman reported to my office for treatment of a painful condition of vagina which she acquired two weeks previously while visiting her husband at an army camp in the South. Inspection showed two small ulcers in lower vagina of a soft nature to touch which discharged a creamy material. A smear and cultures were taken of the lesions following which they were thoroughly cauterized. Sulpha drugs were administered systemically. Smear showed positive for Ducrey Bacilli and several days later Sulpha powder was applied locally to the "sore." Pain was relieved at once and the lesions healed in three days following local therapy.

Case III. A twenty-five-year-old male reported to office with multiple ulcers on both thighs, scrotum and penis. There was inquinal adenopathy. The ulcers were hard and firm, feeling as if a piece of paper were under each. Wassermann test for lues was positive. Hostory of contact was with soldier's wife in a nearby town twenty days before affliction was noticed. Treatment with mercurial ointment locally and arsenic intravenously resulted in rapid disappearance of lesions. Contacts were notified, tested and treated.

Case IV. A twenty-year-old male reported to my office to have his "tonsils removed." Examination showed marked adenopathy both cervical regions and a lesion on upper lip which he described as a "cold sore." Further examination revealed a firm ulcer on penis. Girl friend and shipyard worker accompanying said patient was contacted and examined. She, too, was found to have a lesion of upper lip stereoscopically coinciding with that of the male. Diagnosis of lues was confirmed by positive serology in both patients, treatment started with consequent disappearance of all external evidence of the disease in the course of several days.

Presidential Address—Continued from page 136

shades of those who have fought and won, hover over us; the memories of their sufferings, sacrifices, disappointments and successes, remain to inspire us.

The sun never sets on any land, or fails to shine on any group of people anywhere today, but have received some benefits from those who bear the winged wand of Mercury. Not in relief from physical suffering only, but help also in the Arts and Sciences.

It is a debatable question whether we shall break the bonds of tradition to become articulate. Or shall we, in silent conservative dignity, permit others to profane our heritage and exploit our labors.

To quote from the last stanza of that immortal poem by Dr. McRae:

> "Take up the quarrel with the foe
> To you from failing hands we throw
> The torch, be yours to hold it high."

Let us take up this Quarrel, carry it into the very teeth of the enemy, by improving the standards of Public Health and so make the world a better place to live in.

Some Remarks About the Aschheim-Zondek Pregnancy Tests

From the Roscoe B. Jackson Memorial Laboratory
Bar Harbor, Maine

By Elizabeth Fekete

During the past six years the Roscoe B. Jackson Memorial Laboratory has performed nearly 5,000 Aschheim-Zondek pregnancy tests for doctors of the State of Maine. As the number of the tests that we have been called upon to perform has increased steadily, it seems permissible to assume that the service has been satisfactory. However, we feel that the value of the test could be further increased. To this end we would like to point out some facts gained by analyzing the data of the last 1,000 tests and offer some suggestions.

It is well known that in young girls at the occurrence of puberty the menstrual periods often show irregularity. However, out of 54 specimens of patients whose ages were between 13 and 17 years, 35 (64.8%) proved to be pregnant—1 at the age of 13, 2 at 14, 3 at 15, 11 at 16 and 18 at 17.

Irregular cycles can be expected during menopause which occurs around 46-50 years of age. Seventy-one tests were performed on women between the ages of 46-50 and 5 of these were positives. The oldest positive was 49 years old.

In a few cases we were informed that there was some doubt about the correctness of our reports and were asked to repeat the test. In some such cases our original report proved to be correct, in others which were usually false negatives the report was incorrect. False negative reactions are usually obtained because the test is made too early or when the urine used is not a morning specimen. Correct results cannot be expected sooner than one week after the patient's missed menstruation.

False positive reactions were reported to be obtained in women: (a) nearing menopause, (b) having primary ovarian failure which results in overactivity of the anterior pituitary, (c) having certain types of ovarian cysts and (d) with hyperthyroidism.

Answers to a questionnaire which we sent out to a group of doctors concerning 278 tests showed that all our positive reports were correct, and that in 2 cases (0.78%) we gave false negative reports. It would greatly increase the value of our collected data if the physicians would notify us every time our reports definitely prove to be incorrect and perhaps help us trace the reason for the false reaction.

In the case of a hydatid mole the quantity of chorionic hormone present in the urine is much larger than in a normal pregnancy. By performing a quantitative test the two conditions can be differentiated. A positive reaction persists for about 2 months after the expulsion of a hydatid mole. It becomes negative after about 10-14 days post partum.

The test also has definite diagnostic value in cases of chorionephithelioma of the testicle or testicular teratoma with chorionepitheliomatous areas.

Recently Burdick and his co-workers reported that pregnant mice were very sensitive to pregnancy urine extract. The injection of a positive urine induced ovulation in a pregnant mouse in about 24 hours. Our observations have confirmed this report, and although the details involved in this rapid test will make it more expensive we will be able to perform it on cases in which a quick report seems really important on the judgment of the physician and is requested.

The Laboratory uses the data derived from the tests as research material with which to analyze hormonal and other differences between its strains of mice. It is, therefore, able to perform the tests at a cost below that usually charged.

Reference

Burdick, H. O., Huber Watson, Vincent Ciampa and Thomas Ciampa. A rapid test for pregnancy gonadotropins on the basis of induced ovulation in mice. *Endocrinology* 1943, 33:1-15.

The President's Page

Post Mortem

The 1944 Convention has drifted into history. Certain conclusions may be drawn from its events. From the delegates' meeting we gain the impression that we possess no ingenious devices for limiting the point of view and bringing the picture into focus but the idea emerges that the Association intends to understand all phases of prepaid medical care plans before committing us to such a program. There is confusion in the minds of many of us concerning the differences between non-profit prepaid medical care and the offerings of commercial insurance companies. There are wide basic differences and only careful study by the individual members of the Association will make us better prepared to consider the question when we meet again.

Impressive indeed were the quality and variety of the scientific program. "Never better," was the comment heard everywhere. That such an array of talent could be brought together in war time brought many compliments for Dr. Roland McKay and his associates on the committee.

No weaknesses appeared as the program unfolded and the rule placing time limits on speakers was forgotten in the intense interest of their messages.

For many of us the most exciting development of the entire convention was the prospect of a Medical School for Maine dangled before our eyes by our virile president-elect Adam P. Leighton. Great encouragement and approval was given to the project by Frank H. Lahey in private conversation. At last this would seem to be a project upon which we may all unite. In the past our not too rugged individualism has been at once our charm and our undoing, but here is a rallying point. Only a general demand and a prodigious amount of work seem necessary for realization.

Plans for next year's convention must include the time, the place, the program. Suggestions from members of our Association regarding any or all of these questions mailed to Dr. Carter, our Secretary, will be a real help. It is not too early for suggestions.

R. V. N. Bliss, M. D.,
President, Maine Medical Association.

Editorials

The Ninety-First Annual Session

The Ninety-first Annual Session of the Maine Medical Association was held in Rockland, June 25, 26, and 27, with headquarters at The Sam O set. This was the most outstanding meeting in recent years in terms of attendance and quality of program, although one hundred and eighty-five members are absent in the armed forces; most of them too distant to permit attendance. The registration of 209 physicians and 153 lay guests far exceeded all expectations.

The program committee is to be congratulated on arranging one of the best programs in the history of the Association.

At the Second Meeting of the House of Delegates, Thomas A. Foster, M. D., of Portland, was re-elected Delegate to the American Medical Association for 1945 and 1946. C. Harold Jameson, M. D., of Rockland, was re-elected Councilor for the Third District, and John O. Piper, M. D., of Waterville, re-elected Councilor for the Fourth District. Standing Committees as appointed by the Nominating Committee were approved by the House and are published elsewhere in this issue, as are the Special Committees appointed by the President, Doctor Bliss.

Proceedings of the First and Second Meetings of the House of Delegates will be published in later issues of the JOURNAL.

The Council elected E. Eugene Holt, M. D., of Portland, Chairman for the ensuing year at the organization meeting held Tuesday, June 27th.

The twenty firms which made up the second largest exhibit of medical and surgical supplies in the history of the Association are to be commended for their continued support of the Association, and should in turn receive the wholehearted support of every member.

The President-Elect

Delegates at the 91st annual convention, held at The Sam O set, Rockland, June 26th, named Adam Phillips Leighton, M. D., of Portland, as the president-elect.

He was born in Portland, Maine, January 23, 1887, and attended public schools there, the Holbrook School in Ossining, N. Y., and Phillips Exeter Academy. He was graduated from Bowdoin Medical School in 1910, served a one-year interneship at the Maine General Hospital, Portland, and then studied abroad at the Rotunda Hospital, Dublin, Ireland, and in the Schauta Klinik, Vienna, Austria.

Dr. Leighton opened a private practice in Portland in 1912 and in 1913 founded a private maternity hospital on Emery Street, which he successfully conducted until 1944 when he closed it because of wartime conditions.

During World War I he served as a medical officer in the U. S. Navy and at its conclusion held the rank of lieutenant-commander in the naval reserves.

He is a past president of the Portland Medical Club and the Aegis Medical Club. Is a Fellow of the American Medical Association, of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, and a Diplomate of the American Board of Obstetrics and Gynecology.

For 29 years, Dr. Leighton has been a member of the Maine State Board of Registration of Medicine, having served as a secretary and chairman of this organization. On February 15, 1944, he was elected president of the Federation of State Medical Boards of the United States at an annual convention held in Chicago.

Maine Medical Association Officers Elected

at the

91st ANNUAL SESSION

ROCKLAND, MAINE *JUNE 25, 26, 27, 1944*

Adam P. Leighton, M. D.
Portland
President-elect

G. Harold Jameson, M. D.
Rockland
Councilor Third District, 1947

John O. Piper, M. D.
Waterville
Councilor Fourth District, 1947

Nominating Committee Report

The report of the Nominating Committee as presented and accepted at the Second Meeting of the House of Delegates at the 91st Annual Session of the Maine Medical Association at Rockland, Maine, June 26, 1944.

Nominating Committee

C. Harold Jameson, M. D., Rockland, Chairman
Oscar R. Johnson, M. D., Portland
Harold W. Stanwood, M. D., Rumford
Walter S. Stinchfield, M. D., Skowhegan
Samuel S. Silsby, M. D., Bangor
P. L. B. Ebbett, M. D., Houlton

Scientific Committee

Harvey C. Bundy, M. D., Milo, Chairman
Ralf Martin, M. D., Portland
Herbert C. Scribner, M. D., Bangor
Abbott J. Fuller, M. D., Pemaquid

Committee on Medical Education and Hospitals

Adam P. Leighton, M. D., Portland, Chairman
Allan Craig, M. D., Bangor

Medical Advisory Committee

Allan Woodcock, M. D., Bangor, Chairman
Carl M. Robinson, M. D., Portland
Frank A. Smith, M. D., Westbrook
Willard H. Bunker, M. D., Calais
C. Harold Jameson, M. D., Rockland
Frank H. Jackson, M. D., Houlton
Forrest B. Ames, M. D., Bangor
The Secretary, ex-officio

Legislative Committee

The President, ex-officio
The President-elect, ex-officio
Frederick R. Carter, M. D., Portland, Chairman

Public Relations Committee

Roland L. McKay, M. D., Augusta, Chairman
Frederick T. Hill, M. D., Waterville
Henry C. Knowlton, M. D., Bangor
Harold E. Small, M. D., Augusta
Henry P. Johnson, M. D., Portland

Cancer Committee

Mortimer Warren, M. D., Portland (Five Years), Chairman
Julius Gottlieb, M. D., Lewiston (Four Years)
Arthur H. McQuillan, M. D., Waterville (Three Years)
William Holt, M. D., Portland (Two Years)
Magnus Ridlon, M. D., Bangor (One Year)

Committee on Social Hygiene

Oscar R. Johnson, M. D., Portland, Chairman
Storer W. Boone, M. D., Presque Isle
Leon D. Herring, M. D., Winthrop

Publicity Committee

Frederick R. Carter, M. D., Portland, Chairman
R. V. N. Bliss, M. D., Blue Hill

Financial Advisory Committee

Foster C. Small, M. D., Belfast, Chairman
Warren E. Kershner, M. D., Bath
Ernest V. Call, M. D., Lewiston

Special Committees

As appointed by the President, R. V. N. Bliss, M. D., Blue Hill, in accordance with the By-Laws, Chapter V, Section I.

Committee on Graduate Education

Frederick T. Hill, M. D., Waterville, Chairman
Julius Gottlieb, M. D., Lewiston
E. Eugene Holt, M. D., Portland
Frank H. Jackson, M. D., Houlton
LeRoy H. Smith, M. D., Winterport
James Carswell, M. D., Camden
Thomas A. Foster, M. D., Portland

Tuberculosis Committee

Walter R. Gumprecht, M. D., Bangor, Chairman
Loren F. Carter, M. D., Presque Isle
Charles D. Cromwell, M. D., Fairfield
Lester A. Adams, M. D., Hebron
George E. Young, M. D., Skowhegan
James W. Laughlin, M. D., Newcastle
Francis J. Welch, M. D., Portland
Herbert S. Everett, M. D., St. Stephen, N. B.

Committee on Maternal and Child Welfare

Albert W. Fellows, M. D., Bangor, Chairman
Clair S. Bauman, M. D., Waterville
LeRoy C. Gross, M. D., Auburn
Alice A. S. Whittier, M. D., Portland
Virginia C. Hamilton, M. D., Bath
Guy E. Dore, M. D., Guilford
Thomas A. Foster, M. D., Portland

Committee to Survey Hospital and Medical Care

S. Judd Beach, M. D., Portland, Chairman
Franklin A. Ferguson, M. D., Portland, Secretary
Gerald R. Smith, M. D., Ogunquit (First District)
George L. Pratt, M. D., Farmington (Second District)
Warren E. Kershner, M. D., Bath (Third District)
Edward H. Risley, M. D., Waterville (Fourth District)
Willard H. Bunker, M. D., Calais (Fifth District)
Clyde I. Swett, M. D., Island Falls (Sixth District)
Roscoe L. Mitchell, M. D., Augusta (Department of Health and Welfare)

Committee to Investigate Collection Agencies

Adam P. Leighton, M. D., Portland

Committee on Industrial Health

Harold W. Stanwood, M. D., Rumford, Chairman
Isaac M. Webber, M. D., Portland
Edwin M. Fuller, M. D., Bath
Arthur H. McQuillan, M. D., Waterville
Allan Woodcock, M. D., Bangor
Roscoe L. Mitchell, M. D., Augusta

Committee for Conservation of Vision

E. Eugene Holt, M. D., Portland, Chairman
Howard F. Hill, M. D., Waterville
S. Judd Beach, M. D., Portland
Walter J. Gilbert, M. D., Calais
Warren E. Kershner, M. D., Bath

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John F. Hanson, M. D., Machias

Lt. Col. Stephen A. Cobb Now Heads Army Hospital

Lt. Col. Stephen A. Cobb, M. C., President-elect of the Maine Medical Association in 1942, is now executive officer of a United States Army general hospital in England, according to a release from Headquarters, European Theater of Operations, which states, "In this capacity he coördinates activities and functions as his installation gears itself for invasion.

"Formerly physician for Sanford High School athletic teams, Col. Cobb has continued his interest in athletics by providing a tennis court and a regulation American baseball field for the hospital's medical detachment. The baseball field, which was built in an English meadow, recently was converted into a tent area to provide for the influx of patients expected with the invasion.

"When a soldier talent show from the hospital recently appeared before an English audience at a nearby town, Col. Cobb joined the troupe and baffled the British with a display of American magic. His adeptness at magic has been a source of entertainment for officers and men of the hospital.

"Starting as a first lieutenant in the last war, he spent one year in France with the AEF and came out a captain. He renewed his military career in September, 1942, when he was called to active duty as Chief of Surgical Service with the hospital unit."

"Steve" is known to almost every member of this Association, either in his official capacity on various Association committees, or as Councilor for his district, or for his ability as a prestidigitator.

He is one of the 185 members of the Maine Medical Association, now in Military Service, whose absence was so keenly felt at our recent annual meeting, and who we hope will all be home again before another year rolls around. Until then the best of luck to them all.

Committee on Maternal and Child Welfare

"Concerning Records"

The maternal and infant mortality rate in this State is too high. The administrators of the E. M. I. C. program in Augusta have found that many physicians keep poor records or no records at all. It is quite likely that there is a connection between these two facts. Every doctor should record his cases. If Doctor X cannot remember what pregnant Mrs. Jones' blood pressure was two months ago, how can he tell whether her present pressure of 140 is a normal one for her or is the first rumble of an approaching storm? Was that murmur in Johnny's heart when he was seen two years ago, or has it appeared just lately when his mother says he seems "kind of run down?" Records would tell; simple records, too.

To some the word "records" calls up a picture of a hospital protocol half an inch thick. This is necessary in a hospital because that case history must be intelligible to a stranger ten years from now. A private practitioner needs nothing like that. His records need be intelligible only to himself and can be very simple. We are not concerned now with the man who is trying to prove something by a series of cases, or with a candidate for licensure by a specialist board. We are writing for the man who does not wish to employ a bevy of secretaries, but does wish to do justice to his practice.

The author knows from his experience in keeping his own case records for over twenty years that it can be done very simply. The time spent in jotting down the facts while the patient is in the office adds practically nothing to the length of the call. The patient needs time to tell the story (you can write it down then), and to dress after the examination; you can note the findings then. If there is a slight increase in time spent, charge it up to self-discipline. Records will keep one on his toes. No one wants to file sloppily kept ones.

The indispensible basis for simple streamlined records is the physician's sure knowledge that he takes an adequate history and that he does a *complete* physical examination at the first visit at least. Only under those circumstances can he *know* six months later that parts not mentioned were found normal. Of course the habit of good history taking and completely examining the patient improves the work and reputation of the physician. "But," says someone, "doesn't that take a lot of time?" Certainly not. A complete routine examination of an unclothed child can be done in less than ten minutes. The physician soon learns the art of keeping the discursive mother in line and of getting the facts in an orderly manner. Methodical history taking is a great saver of time and effort, not only in getting facts but in permitting short cuts in records. Pediatric and obstetric records are the subject now, but the principles apply to any type of case. Certain questions are always asked in a particular type of case, and a complete physical examination always done. Without this there can be no short-cuts in recording which will make records understandable to the physician himself six months or more later.

Let us examine a few specific examples: First, a feeding, or nutrition, or chronic illness problem in an infant.

Naturally the first line carries the name, age, father's initials, and address. The next line after the date begins "first child, etc." Realizing that he has a definite routine, the physician seeing this "etc." any time in the future knows that he has asked the questions which complete the statement "first child, healthy parents, born at full time after a normal delivery, normal at birth." Three words have done the work of fourteen, and the physician *knows* a year or more later that he inquired for evidence of birth injury and found none. "Third child, etc." means all of the foregoing plus the fact that the two older children are living and well. B. W.—7 lbs., B. F.—1 mo. are obvious abbreviations. No comment on the B. F. so the infant did well on it. "Now has 12-24-5 DM" refers to ounces of evaporated milk, ounces of water, tablespoons of Dextri-Maltose. If the figures read "24-12-5" they would mean cow's milk, water, and Dextri-Maltose. No word about intervening formulae so they were of the

same nature and well tolerated. O. J. and C. L. O. mean that the baby is taking adequate amounts of orange juice and cod liver oil. Then might follow the mother's complaint. This can usually be summarized in a word or two, or often the interpretation is obvious and is so set down, eg., "hungry." Weight 12 lbs., physical examination normal. The baby was examined nude, and nothing wrong was found, and his mentality seemed normal. A few lines here have taken the place of a long history.

Often there is a stormy feeding history. Often it is not necessary to record every formula and the reaction to each. There is usually a pattern, and questioning often elicits a common factor. This can often be set down briefly but adequately with the probable cause, "various formulas," "gas," "colic," "loose stools," Jersey milk (or high carbohydrate, much handling, etc.)

For the older child a little thought and practice will develop many short cuts, but all must be based on adequate history and complete physical examination. The physician must know that he inquired about pertinent facts, then, for example "P. H. negative" in a suspected heart case means that sources of infection have been asked for and not found. Even such complicated histories as behavior problems can often be shortened by a simple reference to the main factor, "overfatigue, school, habits, etc." after the main symptoms have been recorded.

Obstetric records can be shortened greatly by adherence to the same principle of adequate history and complete physical examination. The physician must *know* that he does not rely on the volunteered information but really asked the questions. "P. H.—neg." then means something. As the case goes on "no bad symptoms" can take the place of "no headache, visual disturbances, dyspnoea, gastro-intestinal disorders, urinary troubles, or oedema." On the other hand stream-lining can be overdone. "Everything O. K." may mean what it says but offers no comparison for later observation. Blood pressure, weight, state of uterus, and laboratory work must be recorded.

Records adequate for the use of a private practitioner, at least for pediatric and obstetric cases, can be kept on a 5 x 3 card. One or two will see an infant through his first year and a woman through her pregnancy. A four compartment filing case will fit handily on the doctor's desk. One file can be reserved for current cases and the others for finished ones. What to do with old records poses a problem. It is obviously impractical to keep all records. As far as pediatrics is concerned, routine feeding, histories, and minor illness notes may as well be discarded after a few years. It is hardly worth while to keep any ordinary history of a patient seen once or twice five years ago.

Obstetric records should probably be kept as long as the patient is in town or until several years have elapsed. The author has had almost no inquiries about pediatric records several years old. A form for immunizations and communicable diseases which can be given to the parents is often helpful now that many schools require that information.

We urge all physicians to develop a standard routine for histories and physical examinations, thereby facilitating the keeping of satisfactory records. Records are helpful and important.

Your Committee on Maternal and Child Welfare.

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Secretary, Leroy C. Gross, M. D., Auburn

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County News and Notes

Kennebec-Somerset-Waldo

A joint meeting of the Kennebec, Somerset and Waldo Medical Societies was held immediately following dinner at the Elmwood Hotel in Waterville, June 8, 1944, at 6.30 P. M.

Dr. George E. Young, President of the Somerset County Medical Association, presided. On motion it was decided to dispense with the readings of the previous minutes of the three societies.

The meeting was called to act on the matter of "Shall the Maine Medical Association Sponsor a Prepaid Medical Service Plan" and to instruct our delegates to the Maine Medical Association meeting in Rockland.

The question was taken up and discussed by Dr. John O. Piper, Chairman of the committee appointed from the Maine Medical Association Council to study the various plans. Considerable discussion brought out many thoughtful points from various angles of the question.

The Secretary of Waldo County Society informed the joint meeting that in view of the fact that his Society had already voted against sponsoring a medical insurance plan, no new action could be taken at this meeting. Finally on motion by Dr. E. H. Risley it was decided that "Kennebec and Somerset Counties go on record as being in favor of some plan of Prepaid Medical Insurance without instructing the delegates as to the exact method of plan." This motion was voted upon unanimously by Kennebec and Somerset Counties and delegates were notified to that effect.

Twenty-eight members were present at the meeting.

Respectfully submitted,

CLAIR S. BAUMAN, M. D., *Secretary*,
Kennebec County Medical Association.

S. J. Beach, M. D., Elected President Ophthalmological Society

The American Ophthalmological Society, at its 1944 meeting at Hot Springs, Virginia, elected S. Judd Beach, M. D., of Portland, President. This is the first time in the history of this Society, the oldest ophthalmological society in the world, that the presidency has come to Maine.

Francis J. Welch, M. D., Re-elected Governor American College of Chest Physicians

At the annual meeting of the American College of Chest Physicians held at Chicago, June 10-12, 1944, Francis J. Welch, M. D., of Portland, was re-elected as the Governor of the College for a term of three years.

Necrology

Edward Moody Cook, M. D.,

1899-1944

Edward Moody Cook, M. D., 44, practicing physician in York, Maine, since 1926, died Saturday, May 21, 1944, at his York Harbor residence.

He was born at York, July 10, 1899, son of Edward Chase Cook, M. D., and Sally Moody Cook. He was graduated from Oak Grove Seminary, Colby College, attended Bowdoin College and received his medical degree from Harvard in 1924. He interned at the Worcester City Hospital, Worcester, Massachusetts.

During World War I, he served overseas with the Naval Railway Battery commanded by Admiral Plunkett.

Doctor Cook was a member of the York County Medical Society, the Maine Medical Association and the American Medical Association. He had served on several Maine Medical Association committees, and held offices in the York County Society.

He was a member of the First Parish Church, of St. Aspinquid Lodge, and of the Edward E. Ramsdell Post, American Legion.

Doctor Cook is survived by his wife, the former May Greenlaw of Deer Isle, one son, Edward Moody Cook, Jr., USNR, who is taking a pre-medical course at Boston University, and by his mother, Mrs. Sally Moody Cook.

Notices

American Board of Ophthalmology

CHANGE OF ADDRESS

Please note that the Executive Office of the Board has moved.

All correspondence should be addressed to the American Board of Ophthalmology, Cape Cottage, Maine.

NEW DIRECTORY

The third edition of the Directory of Medical Specialists listing names and biographic data of all persons certified by the fifteen American Boards is to be published early in 1945.

EXAMINATIONS, 1945

Los Angeles, January. During Mid-Winter Course. (This examination to be held if the number of applications warrant it.)

Deadline for applications: October 1st.

New York City, June. Exact dates to be announced in various Journals about January 1st.

Deadline for applications: December 1st.

Chicago, October. Exact dates later.

Deadline for applications: April 1st.

Note: All examination dates contingent on war and transportation conditions.

Please write at once for application blanks to: American Board of Ophthalmology, Cape Cottage, Maine.

University of Illinois College of Medicine

The University of Illinois College of Medicine announces that its fall didactic and clinical refresher course for specialists in otolaryngology will be held at the College from September 25 to 30, inclusive.

The fee for the course is $50.00. Since registration is limited to twenty-five, applications should be filed as early as possible. Write for information to Department of Otolaryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago 12, Illinois.

Treasurer's Report

To the Members of the Maine Medical Association:

The books of the Association and JOURNAL were closed and audited as of May 31, 1944, by Jordan and Jordan, Accountants and Auditors, Portland, Maine, who have "found the same complete and correct in all details of record," and who have submitted the following statements "properly drawn up to show the true financial position of the Association, May 31, 1944, and the income and expense for the year under review."

FREDERICK R. CARTER, M. D.,
Treasurer.

BALANCE SHEET, MAY 31, 1944

ASSETS

Cash in Banks		$15,540.65
Accounts Receivable:—		
Exhibit Space	$413.00	
Dues	180.00	
Advertising	320.96	
Sundry	16.65	
		930.61
Securities		6,205.00
Furnishings and Equipment		1,092.59
Impounded Cash		1,099.53
Annual Meeting:—		
Expense Deferred		14.63
Trust Fund Investments		2,381.31
Total Assets		$27,264.32

LIABILITIES, CAPITAL AND TRUST FUNDS

Withholding Taxes		$ 49.00
1944 Exhibit Space Deferred		735.00
Capital Account:—		
Balance June 1, 1943	$23,793.97	
Deduct:—		
Legislative Committee Expenses Prior Year	171.70	
	$23,622.27	
Add:—		
Income in Excess of Expense, One Year	476.74	
		24,099.01
Trust Funds		2,381.31
Total Liabilities, Capital and Trust Funds		$27,264.32

TRUST INVESTMENTS AND FUNDS
MAY 31, 1944

Prince A. Morrow Trust:—		
12 shares American Agricultural Chemical Co. (Cost)	$348.00	
Canal National Bank — Savings No. 3905	771.72	
Fidelity Trust Co. — Savings No. 54236, Impounded	24.26	
		$1,143.98
Thayer Library Trust:—		
Canal National Bank — Savings No. 3903	$1,102.49	
Fidelity Trust Co. — Savings No. 54631, Impounded	134.84	
		1,237.33
Total Trust Fund Investments		$2,381.31

Prince A. Morrow Fund:—		
Principal	$568.52	
Income	575.46	
		$1,143.98
Thayer Library Fund:—		
Principal	$1,229.72	
Income	7.61	
		1,237.33
Total Funds		$2,381.31

STATEMENT OF REVENUE AND EXPENSE
ONE YEAR ENDED MAY 31, 1944

REVENUE

Dues	$ 6,372.00
Income from Investments	501.54
C. M. A. B. Advertising	2,618.08
Local Advertising	1,073.69
Subscriptions and Sales of JOURNALS	29.35
Total Revenue	$10,594.66

EXPENSES

Salaries:—		
Dr. Carter — Secretary, Treasurer and Editor	$2,200.00	
Mrs. Kennard—Assistant Secretary	2,000.00	
Travel and Other Expenses:—		
President	10.75	
Secretaries	26.71	
Councilors	208.68	
Office Expenses:—		
Supplies and Stationery	291.76	
Postage and Mailing Expense	189.78	
Rent	300.00	
Telephone	175.90	
Lights	12.05	
Auditing	61.51	
Miscellaneous	63.18	
Committees — Special	79.40	
A. M. A. Meeting	135.54	
Medical Advisory Committee	500.00	
Annual Meeting	201.65	
Printing	3,459.75	
Plates	201.26	
Total Expenses		10,117.92
Revenue in Excess of Expense — One Year		$476.74

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS
ONE YEAR ENDED MAY 31, 1944

Cash in Banks, June 1, 1943		$14,321.62
RECEIPTS		
Received from Dues	$6,320.00	
Income from Investments	501.54	
Exhibit Space Rentals	322.00	
Liquidating Dividend — Fidelity Trust Co.	202.26	
Subscriptions and Sale of JOURNALS	29.35	
Advertising	3,684.82	
Refunds	30.96	
Withholding Taxes	361.88	
Mortbon Corp. of N. Y. "B" 5's, 1951, called at 100	400.00	
		11,852.81
		$26,174.43
DISBURSEMENTS		
Salaries	$4,200.00	
Traveling and Other Expenses	246.14	
Office Expenses	1,094.18	
Committees and A. M. A. Meeting	386.64	
Annual Meetings — 1943 and 1944	216.28	
Medical and Advisory Committee	500.00	
Printing and Plates	3,661.01	
Gerrish Memorial Library — Postage	16.65	
Withholding Taxes	312.88	
		10,633.78
Cash in Banks — May 31, 1944		$15,540.65
Canal National Bank — Checking Account	$4,329.16	
Canal National Bank — Savings Account	1,185.41	
Maine Savings Bank	4,803.05	
Portland Savings Bank	4,763.56	
First National Granite Bank	459.47	
		$15,540.65

SECURITIES — BONDS

MAY 31, 1944

Description	*Cost*
$2,000 Commonwealth of Australia, Ext. Loan 30 Yr. 5's, 1957	$1,960.00
$700 Prudence Bond Corp., 1st Mtge., Coll. Series 6, 5½'s, 1936 (Defaulted)	700.00
$3,000 Portland Terminal Co., 1st Mtge., 5's, 1961	3,045.00
$500 Mortbon Corp. of N. Y. Reg. Coll. "D", 5's, 1956	500.00
10 Shares Mortbon Corp., V. T. Class "A"	
	$6,205.00

Book Reviews

"The Compleat Pediatrician"

(Practical, Diagnostic, Therapeutic and Preventive Pediatrics)

By: W. C. Davison, professor of pediatrics, Duke University School of Medicine, formerly acting pediatrician in charge, the John Hopkins Hospital.

Fourth Edition.

Published by Seeman Printery for Duke University Press. Price, $3.75.

The fourth edition of Dr. Davison's ever popular writings on pediatrics abundantly reflect the times in that he virtually goes to war. He devotes numerous chapters in this latest effort to a discussion of tropical diseases which, he says knowingly, will become increasingly important to civilians when those in the Armed Forces return to private life.

The first three editions of The Compleat Pediatrician, which appeared in 1934, 1938 and 1940, respectively, have been completely sold out — a reflection of the value of Dr. Davison's research endeavors. Combining the more essential and pertinent material, findings and deductions of the earlier works, Dr. Davison changed 7,000 lines from the third edition and came forth with this new revealing compilation.

Here is an interesting, absorbing and valued text — a book not to adorn a medical book shelf, but one which has every day value — and use.

"Synopsis of Pathology"

By: W. A. D. Anderson, M. A., M. D., assistant professor of pathology, St. Louis University School of Medicine; pathologist, St. Mary's Group of Hospitals.

With 294 text illustrations and 17 color plates.

Published by The C. V. Mosby Company, St. Louis. Price, $6.00.

Overcoming many of the usual obstacles that accompany efforts to condense and simplify standard textbooks or widely read reference works, Dr. Anderson has given his medical colleagues this Synopsis of Pathology intact with fundamentals, but minus a maze of details which altogether too often obscure the facts.

Dr. Anderson's rather elaborate undertaking fills a gap between elementary manuals of pathology and an abundance of larger textbooks. At the conclusion of each of his 25 chapters, however, is a listing of larger text and reference books which can augment the concise, compact and condensed synopsis presentation.

Actually, this synopsis provides the essentials and broad outlines involving anatomy, histology, embryology, physiology, biochemistry and bacteriology.

Numerous illustrations and color plates, vivid word pictures in themselves, supplement the written discussion as penned by Dr. Anderson.

"Collected Papers of the Mayo Clinic and the Mayo Foundation"

Edited by: Richard M. Hewitt, B. A., M. A., M. D.; A. B. Nevling, M. D.; John R. Miner, B. A., Sc. D.; James R. Eckman, A. B.; and M. Katharine Smith, B. A.

With 999 pages and 176 illustrations.

Published by W. B. Saunders Company, Philadelphia and London. Price, $11.00.

A volume of unusual merit! The general practitioner, the diagnostic and the general surgeon will find this absorbing and instructive reading.

The editors in compiling 12 lengthy sections covered the fields of recent advances in chemotherapy; alimentary tract; genito-urinary organs; ductless glands; blood and circulatory organs; skin and syphilis; head, trunk and extremities; chest; brain, spinal cord and nerves; radiology and physical medicine; anesthesia and gas therapy; and a miscellaneous chapter.

Considerable space is devoted to a section on chemotherapy because, the editors noted in the foreword, of a "widespread interest in these therapeutic preparations."

More than 500 different articles form the basis of this elaborate volume.

"The American Illustrated Medical Dictionary"

By: W. A. Newman Dorland, A. M., M. D., F. A. C. S., lieutenant-colonel, M. R. C., U. S. Army; member of the Committee on Nomenclature and Classification of Diseases of the American Medical Association; editor of "American Pocket Medical Dictionary."

With 885 illustrations, 240 portraits and prepared with the collaboration of E. C. L. Miller, M. D., Medical College of Virginia.

Published by W. B. Saunders Company, Philadelphia and London. Price, $7.00 plain; $7.50, thumb-indexed.

Dr. Dorland's 20th edition of The American Illustrated Medical Dictionary can rightfully take a place among the better word books available to the profession. The result of careful, deliberate and intensive preparation, this dictionary is as up-to-date and fresh of material as today's headlines!

The editor does not intend for this dictionary to be an encyclopedia, rather he followed a middle course between the large, unwieldly lexicon and the abridged students' dictionary. As a consequence, this 20th edition is full answer to demands of the medical man for a dictionary with convenience of consultation.

The word book covers every department of medicine and surgery through the addition, over previous volumes, of hundreds of new words in many fields, including synthetic drugs and medical preparations. Clear, full definitions and pronunciation codes set this dictionary apart from others. Being one of the newer books of its kind on the market, it contains words and definitions which have cropped out of World War II.

The 885 illustrations and 240 portraits, each indexed, aid no little.

The Journal
of the
Maine Medical Association

Volume Thirty-five Portland, Maine, August, 1944 No. 8

*A Medical Metamorphosis**

Adam P. Leighton, M. D., Portland, Maine

In foisting this dissertation upon you this afternoon, I am most apologetic because I have nothing of scientific value to offer, and, in fact, I am harping away in my usual manner upon an old familiar subject with remarks which will be but a repetition of those made on previous occasions. The title would appear to be a misnomer, for the definition of the word "Metamorphosis" is to transform or to transmute. A change of form or structure is usually the meaning, and yet from its Greek etymology it is more aptly explained as a transition. The medical muddle of today may be called a metamorphosis because a change in form in medical practice seems to be contemplated, if not already at hand.

When I accepted this invitation to take part in today's program, it was my intention to present more or less in detail a historical review of Maine medicine as I had known it in these past thirty-eight years, and to recount a few of its problems and successes. I wanted to show, if possible, how, thru this transitory period, and in this comparatively short span of time, we arrived in the chaotic state of affairs with which we are faced today. I have intentionally omitted and deleted much of the historical text for it "smacked" too much of rank sentimentalism, and it was patently ill-timed. The moment has arrived, however, when one should speak freely and candidly of our medical problems, and never before has discussion and action been so urgently needed. I shall have the temerity to offer several solutions of these problems, and one redeeming feature of this presentation is the fact that it is decidedly brief and to the point, at least.

I never expected to live long enough or to have been engaged in the practice of medicine for a sufficient period of time to allow me to reminisce. It would seem that this is but a senile change which stimulates and allows some of us who have been in this game for the past three or four decades to wax pessimistic and to be critical. After thirty-five years of active practice, the realization comes to me that some of us are living on "borrowed time," and as we calmly await the call of the inevitable coronary, it is not surprising that we become disgusted, dismayed and fearful as we observe the present-day attempt to disrupt private and personal enterprise in medical practice by meddling governmental activities, and the usurpation of our

* Presented at the 91st Annual Session of the Maine Medical Association, at Rockland, Maine, June 27, 1944.

rights and privileges by a horde of pseudo-medical practitioners who have "slipped in" thru the back door of medicine.

The unfortunate part of it is the fact that we have no one to blame but ourselves for the predicament with which we are now faced.

There are three distinct etiological factors responsible for this mess. In succession these may be named as, first, the closing of the Medical School of Maine, secondly, the debacle of 1929 when this Association "sold out lock, stock and barrel" to the Osteopaths, and lastly, the advent of the present war. The first two mistakes were ours alone. The War put on the finishing touch, and now with the spectre of National Socialized Medicine before us, and the panicky attempt of certain well meaning members of our own Association to evolve some system or plan of prepaid medical insurance to circumvent this apparent invasion of our rights of practice, the ways, I honestly believe, are greased for the launching of another catastrophe, if we don't watch out and remain alert to the situation.

For thirty years I have been privileged to be a member of the Maine State Board of Registration of Medicine. It is with pride that I look back upon the activities and efforts of this organization, for within this time the many matters pertaining to registration, licensure and examination have been carried on at the highest level, and I again say that our requirements for practice are not surpassed by any other State in the Union. We, the members of this Board, thru the medium of licensure and interest in medical legislation, have indeed had the opportunity to view the kaleidoscopic parade of events in medical affairs in recent years. We have, undoubtedly, seen the best days of medicine, and before us are troublous times. I do not refer to scientific medicine, in making this statement, because, obviously, it will rise to higher peaks than ever before, but refer wholly to our professional well being. While this sounds like pessimism, I assure you that there is no spirit of defeatism linked with it.

I wish that I might digress and go back thirty-five, twenty and fifteen years and recall the good old days which went hand in hand with the teaching of medicine in this locality.

The Medical School of Maine was a small school nurtured under the wing of Bowdoin College, and it was a remarkably good school. Most of the students were Maine boys who upon graduation, for the most part, went back to their home towns to practice, or had in mind some special location in Maine in which to settle. This school enjoyed an enviable reputation, and hundreds of well and practically trained men came from within its portals, many of whom later attained national fame. It filled an important part in the life of Maine and its people, and provided ample care for its citizens for over a century. It was a sorry day when this institution was allowed to close its doors, and we have never ceased to regret this unfortunate occurrence. It went out of existence because the Governor, the Legislature, the Trustees of Bowdoin College and other so-called leaders of the profession were unwilling to put forth the effort necessary to enlarge its plant and to permit of full time teachers, thereby embracing the plan incorporated in the Flexner Report of the Carnegie Foundation for Advancement of Medical Teaching. When help was not forthcoming, it seemed better that the school should go out of existence as a Class A institution than to slide backwards in its classification. This year was, indeed, the start of many of our present-day difficulties, and from the serenity and supremacy of medical practice, which I am thankful some of us still recollect, thru selfish indifference and our usual "Let George do it" attitude, we allowed ourselves to back stern foremost into the exasperating and ridiculous position of the present time.

The closing of the Medical School and the ending of World War I were coincident happenings and may I for a few moments briefly consider the train of events and changed medical picture which followed in their wake. The rural districts usually supplied by our medical graduates in the years following began to suffer because of the general unwillingness of the graduates of other medical schools to go back to the crossroads to practice. The out-of-state men and our own boys who put in eight or ten years in procuring a medical education, followed the modern trend and located in the city where social, hospital and business opportunities naturally lured them. The men who went to War in 1917 did not return to rural practice in very large numbers, and many of these fields, having been left open since that time, have

given opportunity to cultists to early and successfully invade the territory.

From 1921 to 1929 these rural districts suffered further, and the gradual diminution of the number of medical men became more and more apparent. The trend of modern life, good roads, automobiles and the higher plane of living had much to do with it. As doctors gradually moved into the cities and were less inclined towards rural practice, many of our country districts became destitute of medical care. During this period our State Board of Registration of Medicine showed a 30 to 35 per cent decrease in the number of applications for the right to practice in Maine. This was a most evident effect of the loss of medical teaching in our State. The osteopathic profession at this moment was quick to see the advantages offered them, and their members began to quietly move into these desirable locations.

The real pay-off came in 1929! Up to this time the osteopaths who in 1915 had gained legislative recognition, thru the institution of a separate Board of Examiners to regulate their practice, had bided their time, and with the aid of excellent legal talent and political intrigue, they regularly appeared at the various legislative sessions, endeavoring to strengthen their case by obtaining added rights and privileges.

For years the Maine Medical Association thru its chosen representatives journeyed to the State Capitol at the time of each session of legislature, and fought off the attempt of the osteopaths to gain more favorable legislation, and up to 1929 this particular cult practice was kept well within bounds. There came into power in the Maine Medical Association a group of officials with good intentions, but with a decided lack of foresight, who came to the conclusion that it was useless to fight the osteopaths any longer. They threw up their hands and stated that there was no fear of competition, and by vote of this Association, and thru the action of this House of Delegates, it was decided that no longer would we appear at Augusta and attempt to fight what might be adverse legislation. Therefore, not one word of medical opposition was heard when the Osteopathic Bill was presented for hearing and action. The osteopaths were given the right to practice surgery and obstetrics, and to administer such drugs as were necessary for treatment in these particular medical branches.

Can you imagine a more incongruous state of affairs? Two schools of practice, diametrically opposed in basic theory, with separate boards of examination and licensure, one regular medical and the other ostensibly and primarily a drugless system, with the licentiates of each engaged in the practice of medicine!

I have no quarrel or argument with a man who differs with me in matters pertaining to the treatment of the sick. That is his inherent right, and the school of practice which he embraces, no matter how fantastic or peculiar may be its theory, is none of my concern. All I ask is that he practice that which he preaches, and refrains from plagiarizing the phraseology of our textbooks, the larceny and appropriation of our technique and the encroachment upon our rights and privileges of practice, by attempting to masquerade as a medical man in the eyes of the Public.

The Osteopathic Invasion is on, and whether you like it or not, you must agree that it is competition. You are probably saying, "Yes, it is so, but what are you going to do about it?" Many of my confreres scoff at it, and others are too complacent to let it bother them. It is of little import to those of us who have enjoyed successful practice all these years, but with true unselfishness, we should give some serious thought to the younger men who will return after the War and will expect, at least, to find opportunities awaiting them, the equal of those which they left. It is a sad commentary but true, that our younger medical men, thru patriotism and necessity, gave up everything to enter the armed services of their Country, and while they have been gone and their backs turned, an army of osteopaths has moved in and taken over in their stead. These irregulars have not been allowed to enlist in the medical corps of the Army and Navy because their school of practice is not recognized, yet they stay at home and reap the harvest, and in some instances have been declared essential for the care of the citizens!

Just what may we do about it? My answer is—first of all let us restore and quickly reopen our medical school. The Charter is available and the time is right. I recently brought this to the attention of President Sills of Bowdoin College and I find that there are about $400,000. available in the so-called Garcelon-Merritt

Fund, which, without any doubt, could be used as an initial part of the amount needed to be raised if we were to have again a modern medical school. The income from this portion of the Fund that was devoted to the Medical School in the old days has under the *Cy Pres* doctrine been assigned by the Supreme Court of Maine to the payment of medical scholarships, and under the terms of the decree, Bowdoin College awards in normal times about $8,000 a year to these students in medical schools. If a medical school were to be re-established, I presume we could go to the Supreme Court and have this fund again used for such a purpose. It seems highly proper that the University of Maine should sponsor this medical department, and it should be subsidized by the State of Maine. In these days when we glibly speak of billions, it would seem that we could raise a million dollars thru governmental aid, state aid and other channels to allow for the consummation of this plan and the ultimate establishment of such an institution. The supply of doctors is being drastically curtailed, and the number in the Armed Services is not great enough to meet peace-time demands. There must be a continual flow of young men from medical schools if the public's health is to be properly safeguarded. Maine assuredly will need its full quota in the post war days, and herein lies the necessity for the rebirth of our medical school.

I ask your attention to and consideration of this important matter. Would that such a plan could come true, and that Maine again could house a school of medical teaching and once more be numbered among the States having medical institutions. It would seem that the ideal place for this plant to be situated would be in Portland, the largest city in the State, and having ample hospital facilities. I trust that the membership of this association and its selected officers may see fit to take action to bring about the complete fruition of this idea, and I hope that a committee may be appointed to look into the cost, legislative action and plans which will have to be arranged.

The next step to my mind is the need for legislation to allow for the incorporation of a definition of the practice of medicine in our Medical Practice Act. We have an excellent medical law governing medicine at present, but with this definition added, it would be easier to determine just what is medicine and what is osteopathy. If a D. O. is to be classed in the same category as an M. D., then there is no valid reason why thru legislation, the C. P. A. couldn't take on law practice and the veterinary take on human dentistry. The analogy is correct and fitting.

What is needed especially, is a trained investigator, a man preferably of legal training, who can, under the Medical Board's guidance, ferret out the instances of illegal practice by osteopaths and others, and bring the offenders to the proper prosecuting authorities. We have an ample fund delegated to our use from Board receipts to allow us to hire, at least part time, some spirited young lawyer who could attend to these duties. Several of the States have such an individual associated with their Boards, and the results have been excellent.

Osteopaths have been given an inch and they have taken a mile. They administer drugs and medicines in pulmonary disease, cardiac disorders, specific disease and for other complaints which are in no way related to surgical or obstetrical practice, and play the role of the doctor of medicine when they know they have not the right or the proper equipment. This must be stopped, and I have hundreds of instances in mind with plenty of evidence to prove this point. A little adverse publicity, and they might see the light and, at least, it would educate the laity concerning a matter about which they know little or do not show much concern.

In conclusion, may I briefly allude to the question of Prepaid Medical Insurance, agitation and discussion of which was recently brought to your attention by our local Medical Societies by certain of our well meaning but jittery brethren. Maybe for the post-war days some system of federalized medical care is in the offing, or some system owned, financed and operated by industry will be put over upon us, or some system directed and guided by commercial insurance companies may be the answer. Any of these possibilities seem to me to be most dangerous procedures, and I know you all agree. It calls for a departure from our present day system, and we cannot afford to experiment. One-third of our doctors are away on far-flung fronts fighting for us. They have given up home, their practice and family, and

Continued on page 170

The Browntail Moth

Its Life Cycle. Types of Skin Lesions Produced by the Poison Hairs. Report of a Case of Recurrent Generalized Urticaria Resulting from Contact with Poison Hairs and Its Subsequent Desensitization.

Charles W. Steele, M. D., F. A. C. P., Lewiston, Maine

and

William H. Sawyer, Jr., Ph. D., Professor of Biology, Bates College

Introduction

The browntail moth (Nygmia Phaeorrhea) has reappeared in great numbers in central Maine during the summers of 1940, 1941 and 1942 with a corresponding increase in the number of cases of dermatitis traceable to contact with this insect. Thus, an excellent opportunity to obtain both entomological and clinical material for study and for recording with photography has been afforded. A comprehensive article illustrated and dealing with the life cycle of the insect and with the various types of skin lesions produced by contact with its poison hairs seems timely; particularly, since the moths are on the increase and as none of the original articles dealing with browntail moth dermatitis or the textbooks of dermatology show any pictures of the skin lesions.

Many kinds of insects are known to have irritating effects on the human skin; of all these the worst offender, because of the often serious toxic nature of the lesion which it produces, is the larval or caterpillar stage of the browntail moth, Nygmia Phaeorrhea. (Donov.)

This insect, of widespread occurrence in Europe, Asia, and Northern Africa, was first noted in the United States in Somerville, Massachusetts, in 1897.[1] The caterpillars prefer to feed upon foliage of the apple and related species, but may also be found upon oak, willow, and other common hardwood trees and shrubs.

Unlike the related Gypsy Moth caterpillar, however, the larvae never feed upon conifers, though they may move to them from nearby hardwoods and often pupate among the needles. The caterpillars cause both serious poisoning to many humans and severe economic losses through defoliation of orchards, shade trees, and woodlots. Therefore, determined efforts have been made to eliminate them by arsenical sprays, destruction of their winter nests, and, most important of all, the use of natural enemies. Included among the latter are several species of parasitic insects imported from European habitats of the pest, and a parasitic fungus, Empusa Aulicae, which periodically destroys huge numbers of larvae when conditions of temperature and moisture are favorable to its development. Despite these efforts, however, the insect has persisted, and has spread from Massachusetts to large areas in all the New England states. It has also penetrated into New York, New Jersey and Pennsylvania, as well as New Brunswick, Nova Scotia, and Quebec.[2] In a given locality the infestation may be so slight as to escape notice for several years; then it will suddenly flare up, and the caterpillars become so numerous that individuals susceptible to their poison find that home has become a menace and summer cottages have become untenable. In the northern range of the insect many hibernating larvae are killed by severely low temperatures, and thus these sudden infestations are liable to follow a mild winter. Other factors that allow for heavy seasonal infestations are due to conditions that have prevented the development of a normal number of natural enemies.

Eggs of the insect hatch during the first half of August. The young caterpillars begin to feed at once and after 4 or 5 days they

molt, or shed the thin chitinous covering of the body. In their more northern range this is usually the only molting to occur before hibernation, although the caterpillars shed their *integumentary* covering four times before they are full grown.

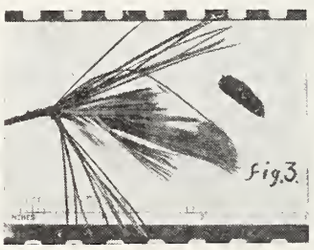
After molting they continue to feed and grow. Silky threads are spun from secretions of modified salivary glands, and these are used to web together the terminal leaves of a twig into a glistening white nest, 2 or 3 inches long. (Fig. No. 1). To this nest the

small larvae retire at night and in it, after feeding has ceased in autumn, they spend the winter in hibernation. Each nest contains all the larvae hatched from a single egg mass, usually two hundred to four hundred caterpillars, and therefore the collection and destruction of these nests in winter, when they are conspicuous on the ends of naked twigs, is one of the best means of control of the insect.

In the spring, the caterpillars, which are now about one-fourth inch long, emerge from the nest and begin to feed when the buds begin to open. They molt two or three times and become full grown the last of June. The caterpillar is now slightly more than an inch long, with brown glistening head and the thirteen segments of the body clothed with tufts of long, flexible, light brown hairs. Eight segments, the 4th to the 11th, inclusive, each bear two tufts of pure white feathery hairs, dorsolaterally placed, so that the caterpillar has a conspicuous chain of white spots along each side of its body, except at the ends. A third type of hair, the poisonous barbed spicules, which are very minute, occur in velvety brown patches on the back and sides, from the 4th to the 11th segments, inclusive. An especially good characteristic for identification consists of two slightly raised, smooth, concave, bright red structures in the mid-dorsal line, on the 9th and 10th segments. These structures appear after the first molt, and at first are light yellow in color. (Fig. No. 2). Walking appendages are present on

all segments except the 4th, 5th, 10th, 11th and 12th.

During the latter part of June the full grown caterpillars weave about themselves thin loose brown silken cocoons within which they change to the dark brown or black, shiny pupal stage. (Fig. No. 3). The pupae are



one-half to three-quarters of an inch long, and the sexes may be differentiated; the pupa which is to produce a male moth being somewhat smaller and more tapering at the posterior end.

In the first half of July, after about two weeks in the pupal stage, the moths emerge. Both sexes are pure white, the female slightly larger, with a wing spread of about an inch and a quarter, and a conspicuous bunch of long glistening brown hairs at the tip of the abdomen, whence the common name. The male has a much smaller tuft of brown or grayish hairs at the posterior end of the body (Fig. No. 4).

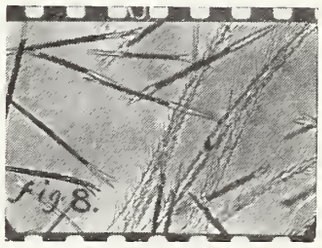
The moths mate soon after emergence and the female lays her eggs in a compact mass covered by the brown hairs from the posterior end of the abdomen (Fig. No. 5). These

brown egg masses, convex in shape and about three-eighths of an inch wide and one-quarter to one-half inch long, are usually deposited on the under sides of leaves during the latter half of July. All the eggs in one egg mass hatch within a few hours of one another, usually about two weeks after deposition.

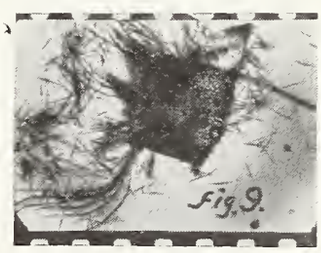
It has been stated above that the caterpillar bears three kinds of hairs. Both the long brown hairs (Fig. No. 6) numerous all over the body, and the white hairs (Fig. No. 7)

which occur in sixteen tufts, bear numerous exceedingly slender sharp branches all along their sides and we have demonstrated that these hairs are capable of causing some mechanical irritation when pressed against the skin. In a very susceptible individual they also seem to cause slight chemical irritation and allergic response, but little indeed compared with the microscopic spicules located in dense cushions on the body.

These spicules are the chief cause of dermatitis and allergic symptoms in cases of browntail caterpillar poisoning. They are about 1/250 of an inch long, bluntly three pointed at the distal end, slender, and tapering to a very sharp point at the proximal end. (Fig. No. 8). The sides bear several minute,



sharp, distally pointed barbs. The spicules are hollow and filled with an amorphous material, which in old ones has shrunk to allow part of the cavity to be filled with air. The opening at the tip is too minute to observe under a magnification of 1000 diameters, but Tyzzer[3] says that when immersed in Methylene blue solution the spicules fill with the dye and we have verified his statement. In full grown caterpillars these spicules occur on segments 4 to 11, inclusive, in slightly raised areas or tubercles, with 4 tubercles to each segment, one on each side of the mid-dorsal line and one on each mid-lateral surface. They first appear immediately after the first molt, when the caterpillar is 5 or 6 days old, and, until late in its development in the following season, are restricted to two dorsal patches on each of the 4th and 5th segments. These poison-spicule areas consist of many slightly protruberant, goblet-shaped receptacles for attachment of the spicules. The circular tops of these receptacles are from 10 u to 20 u in diameter and each contains from 3 to 12 spicules, deeply inserted by their pointed ends in individual narrowly conical sockets (Fig. No. 9).



In an 8-day-old caterpillar, serial sections show under each area of spicules a thick cushion of large, much elongated deeply staining epidermal cells, in a palisade ar-

rangement. The distal end of each cell connects directly with the hair receptacle and with the pointed ends of the individual spicules. Kephart[4] has described two kinds of cells under the poison hairs, hair formative cells and poison gland cells. It is regretted that our material does not show this condition; we hope in a later paper to deal in more detail with the exact mode of development and cell relations of these spicules. It is clear in our slides, however, that the young spicules are comparatively thin walled with much larger cavities than later in their development. Since the elongate epidermal cells are directly connected with the inner ends of the spicules, it is assumed that these cells secrete the poison, which enters the young spicules and later dries to the amorphous form described above. As the caterpillar matures and the chitinous cuticle thickens, the epidermal cells withdraw from direct connection with the spicules, leaving canals in the cuticle from cells to receptacles, as described by Miss Kephart. The spicules become loosened in their sockets and very easily dislodged.

Poisoning by these spicules may occur in several ways besides direct contact with the caterpillar. The molted cuticle, bearing poison spicules, may be blown by the wind against exposed skin. In thickly infested areas, spicules dislodged by movements of the caterpillars among the foliage might be carried by the wind in quantity sufficient to cause poisoning in susceptible individuals. Many of the spicules become caught in the cocoon during its formation, so that the latter is a source of poisoning. The spicules also occur in and on the nests, which may thus be a source of irritation to sensitive individuals. Although no definite cases are known, it is probable that inflammation of respiratory passages would follow inhalation of these structures.

The abdominal hairs of the female moth are of three different kinds: 1. Very long and slender hairs, about 2 u in width and 1 mm. long; the base has an S shaped curve and the distal end tapers very gradually to a sharp point. The surface is covered with barbs, most pronounced at the base and gradually becoming smaller until they nearly or quite disappear at the tip. 2. Still longer and coarser hairs, about 6 to 8 u wide and 1½ to 2 mm. long, smooth, but with 12 to 15 striations running the whole length (appear like modified scales). These hairs taper to the tip, which is an oval enlargement, 2-3 u wide. All hairs are hollow. 3. The barbed spicules like those of the caterpillars, sparsely scattered loosely among the outer ends of hairs. These poison hairs would appear to have been acquired by the moth from the loose web about the pupal case when she emerged from the latter. Their position and relatively small number would indicate the improbability that they are formed on the body of the moth.

The abdominal hairs of the male are quite different from those of the female; all of one kind, obviously modified scales, and showing gradations from flattened scales of various lengths, with forked ends to smooth, rather bluntly shaped ends, 6-12 u wide and ¾ to 1 mm. long, somewhat flattened. No barbed spicules have been observed, but a few may be present, as noted in the female moth.

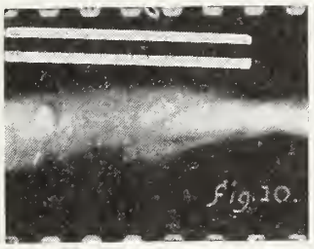
Skin Lesions Produced By the Barbed (poison) Hairs. (Fig. No. 8):

The early observers (White, etc.,) described the skin lesions as a peculiar, itching, more or less confluent, urticarial eruption appearing chiefly on the neck but sometimes affecting the face and hands. The efflorescence was urticarial in character, but very persistent; that is, remaining unchanged for two or three days. The lesions were in some cases arranged in long continuous tracts, as if following the course of the creature upon the skin.

A much wider variety of itchy skin lesions (discrete papules, maculopapules with extensive surrounding erythema, generalized urticaria, and single large localized red areas with vesicular or shallow necrotic centers) have been attributed by patients themselves to poisoning as a result of contact with the browntail moth. Our studies on the poisonous properties of the various kinds of hairs would seem to indicate that any one of the above type of lesions may be produced by the barbed hairs. The sensitivity of the subject,

the number and type of hairs coming in contact with the skin, and the amount of scratching and rubbing done by the patient would appear to be factors determining the type of skin reaction.

Occasionally in certain patients like Carver, whose protocol appears below, the skin may become highly sensitized and may respond with an urticarial type of generalized eruption whenever any of the poison barbed hairs from the adult caterpillar or dust from the caterpillar nests comes in contact with the exposed epidermis. Large itchy wheals with pseudopodia and extensive surrounding erythema developed first at the point of local contact but additional lesions soon appeared in abundance on the non-exposed skin areas of the upper arms, legs and trunk (Fig. 10).



This type of individual is in all probability truly allergic to the poison from the barbed hairs.

On the other hand, one of the authors (Steele) possessed a strong local skin sensitivity without evidence of any generalized allergy. He noted an intense needle-like burning type of local discomfort within half a minute after a few barbed hairs were brought gently in contact with a small area of unprotected skin. A wheal appeared within five minutes and increased rapidly in size, forming pseudopodia and attaining its maximum diameter of 3 to 4 cm. by the end of twenty minutes. This wheal was surrounded by a large area of erythema (Fig. No. 11)

and was accompanied by itching and there was an almost constant desire to scratch or rub the lesion. The discomfort and itching persisted without let-up for an entire week but gradually decreased in intensity during the second week. At first the center of the lesion was vesicular. Superficial central necrosis had taken place by the end of the second day and this was surrounded by considerable induration and erythema. This condition persisted for about a week before it began to subside. It required two weeks to accomplish complete healing of the lesion and cecession of symptoms.

Should a caterpillar crawl across or become crushed against such an exposed sensitive skin, a great number of the barbed poison hairs would certainly penetrate it and would cause immediate intense burning, itching, and discomfort, and the type of vesicular or urticarial lesions described first by White. (Pictures could not at the time be obtained, of this type of lesion).

Penetration of the barbed hairs produced a different type of skin eruption when experimentally applied to the skin of another subject (Robinson). Red macules appeared within twenty to thirty minutes at and adjacent to this point of contact of the barbed hairs with the skin. These lesions were surrounded by an extensive erythema several inches in diameter (Fig. No. 12); but they

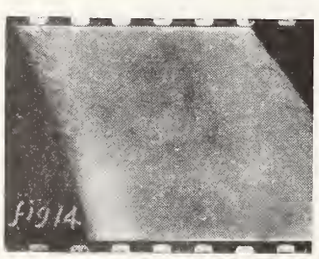
did not go on to vesicular formation or to necrosis, and simply faded out after a few days.

In fact, this type of discrete broad flat maculopapule occurs singly and in groups and is the type of browntail moth skin lesion encountered most frequently in our private dermatological practice (Figs. 13A and 13B). The authors believed that this form of eruption represented the maximum skin reaction to the poisons from a barbed hair when it penetrated the epidermis of a mildly or moderately sensitive person. The symptoms

of itching and burning were moderately severe, but much less intense and of shorter duration than they were in the highly sensitive individual. This type of rash usually faded out within the five- to seven-day interval following the initial contact.

Non-sensitive or immune individuals like one of the authors (Sawyer) had no skin reaction whatsover after the barbed hairs were rubbed into the exposed skin. Slightly sensitive persons developed only a very few small indistinct maculopapules without any surrounding erythema.

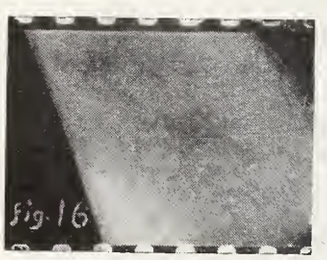
Tyzzer in his treatise on the pathology of the browntail moth, stated that the nettling hairs, when rubbed upon the skin produced a dermatitis; but that none of the other hairs on either the caterpillar or on the adult moth produced a skin irritation. The authors were not able to confirm this statement. The long hairs of the caterpillar when rubbed upon the skin of a highly sensitive individual (Steele) gave rise to a burning sensation and stinging itching discomfort about five minutes after some of the long hairs were rubbed against the skin of the forearm. Within twenty minutes the point of inoculation showed a raised red maculopapule three or four mm. in diameter and was surrounded by an irregular area of erythema about fifteen millimeters in diameter (Fig. No. 14).



The white tufted hair from the adult caterpillar caused the least amount of reaction when put in contact with an alergic skin (Steele); but after a period of fifteen minutes, a faint reddening appeared at the point of contact and inoculation. This went slowly on over the next half hour to the production of a small maculopapular lesion which persisted for about forty-eight hours (Fig. No. 15). The itching was less intense

and of relatively short duration. Neither the long hairs or the white tufted hairs of the caterpillar produced a reaction when applied to a subject with a moderately sensitive skin (Robinson) or on a subject with a non-sensitive skin (Sawyer).

The tail hairs from the adult female moth, when brought in contact with the skin of the forearm of the sensitive individual (Steele) caused a stinging sensation that was felt almost immediately; but it required about twenty minutes to develop a macule 2 mm. in diameter at the point of contact. Subsequently, a few secondary maculopapules appeared in the 2 cm. area of erythema which surrounded the primary maculopapule (Fig. No. 16). Eventually, the same sort of burn-



ing stinging sensation was noted and an erythematous macule developed at the site of contact of the adult female moth tail hairs to the less sensitive skin (Robinson). In a short while this was followed by the appearance of smaller maculo-papular erythematous lesions within the adjacent 2 cm. area (Fig. No. 17).

When examined carefully under the microscope, the brown hairs from the tail of the adult female moth appeared to have stuck to them some of the barbed hairs which one ordinarily sees on the adult caterpillar. The authors suspect that these barbed hairs may have come originally from the adult caterpillar, since these poison hairs are incorporated in the pupae case and are thus in position to stick to the tail of the adult moth as she is emerging from it.

When the brown hairs from the tail of the adult male moth were brought in contact with the skin of the forearm, a reaction was slower in developing and required about thirty minutes for a wheal 2 cm. in diameter to develop. The point of inoculation slowly reddened; and itching and burning sensations, although much less intense, were still definitely noticeable at the point of contact of the hairs with the skin (Fig. No. 18). The itch-

ing at the point of contact was much less intense and much less prolonged than that produced by the barbed hairs from the caterpillar. All the redness of the lesion had faded out by the end of two days following onset.

A binocular dissecting microscope was used to carefully separate the various types of hairs found on the adult caterpillar. Thus, the utmost care was exercised before the tests were run to avoid any possibility of contamination of either the long hairs or the white tufted hairs with any of the barbed hairs.

Furthermore, it seems probable that only those individuals who have extremely high degrees of sensitivity will show lesions when the tufted hairs or the long brown hairs on the adult caterpillar come in contact with the bare skin. Tyzzer's failure to demonstrate evidence that the long brown hairs or the white tufted hairs of the adult caterpillar possessed poisonous properties could most easily be explained on the assumption that he used persons with only mildly sensitive skin for his test subjects.

Treatment of Skin Lesions:

Symptomatic treatment has not proven too satisfactory from the standpoint of relief from the intense itching and burning. Soothing applications have generally been recommended by dermatologists, with the note that the disease was self limited. Alkaline applications have also been suggested.

Most patients report relief from phenol containing lotions or washes. One individual reported that strong creosote solution, frequently applied over several hours, took the "fire" and redness out of the lesions.

The author found that none of the alkaline lotions such as ammonia and weak sodium hydroxide solution were of any avail in checking or neutralizing the poison from the barbed hairs once they had penetrated into the skin. It would seem unlikely that any application locally applied could penetrate the skin far enough to neutralize the poison, once the barbed hairs penetrated to the deeper layers. Consequently, probably all efforts toward prevention must be directed toward the avoidance of skin contact with the caterpillars or to prophylactic immunization; whereas, all treatment of the actual skin lesions produced by penetration of the poison hairs is at present limited to soothing and anti-puritic surface applications. Every effort should be made to relieve the puritis and burning, since, of course, rubbing and scratching only serve to cause deeper and more massive penetration of the barbed hairs and also a spread of the skin lesions. The author found carbolated vaseline to be the most effective local application for relief of the intense itching.

In view of the rather dramatic results obtained in the relief of bee stings, spider bites, etc., with intravenous injections of Neo-Cal-

glucon, it has occurred to us that this preparation deserves a clinical trial in severe browntail moth poisoning. Unfortunately, no suitable cases have been available since the case reports concerning the use of Neo-Calglucon in spider bites, etc., came to our attention.

Our observations concerning the desensitization of a person with urticarial lesions produced by contact with poison material from the browntail moths or their nests, reported in detail below, has convinced us of the practicality of preparing extracts from the poison hairs and the poison glands which could be used to desensitize individuals who cannot avoid contact with the moths and caterpillars. One of us (Sawyer) is working on methods for harvesting the poison hairs and poison glands in sufficient quantity to afford adequate material for extraction. Results of this research will be published in a subsequent paper.

Case Summary on W. C.

The following case summary is of interest because it apparently represents an allergic type of skin reaction to contact with the poison hairs of the browntail moth.

Chief Complaint:

An itching hives type of skin eruption. Itching was intense.

Present Illness:

This patient first presented himself for examination on December 5, 1940, when there was snow on the ground. He complained that during the course of the forenoon he would break out with a generalized, intensely itchy, blotchy, red, hives-type of rash. This eruption usually appeared first on the forearms, the lower legs, or the neck and then spread rapidly to the trunk. The patient had been unable to establish any causative relationship to food but had noted that he was particularly prone to break out when he went to the woods to work, or handled hay in the barn, or went to the well which was under a large elm tree in the yard. The skin eruption disappeared during the night and the patient had observed that the ingestion of beer seemed to alleviate some of the itching and to facilitate sleep.

Past History:

In June, 1940, this patient had an intensely itchy vesicular eruption on one shoulder. Somewhat later, while working in the hayfield, he had been troubled with an urticarial eruption on the lower legs and arms similar to that described in the present illness.

Occupational History:

Patient owns a small farm. His winter work consists in cutting wood and in caring for a small amount of livestock. During the summer he does the usual farm work, which includes haying.

Diet:

Revealed that he usually ate toast or muffins with coffee for breakfast. His customary eggs had been omitted without producing any improvement in the skin condition. Lunch and evening meals usually consisted of meat, potatoes and bread. He drank a lot of beer in the evening and at night because he felt that the beer seemed to relieve the itching.

Physical Examination:

Revealed numerous typical urticarial type of lesions on the forearms and trunk and scattered ones on the upper legs (see Fig. No. 10). The remainder of the examination was negative.

Subsequent Course:

In the beginning the author suspected a foreign protein sensitivity due to food. Consequently, a large series of pressure puncture skin tests were done with all the common foods that the patient normally ate. Moderately positive reactions to the wheat fractions, buckwheat, cucumbers, oysters, peanuts, pecans and beets; and strongly positive reactions to oats and apples were obtained. These foods were all left out of the diet; and in addition, various medications such as ephedrine, stramonium, calcium, etc., were tried without producing relief. Twenty cc. of his

own blood was injected intramuscularly with only temporary improvement. The true nature of the eruption did not become apparent until February, 1941, when the patient became suspicious that he might be sensitive to browntail moth. He obtained a dead moth from a nest and had rubbed it gently against the skin of his forearm. Within 15 minutes, typical urticarial lesions appeared at the point of contact and were followed by similar ones on the upper arms and trunk and thighs, and to a less extent on the lower extremities. This test was subsequently repeated in the office and shown to bring out the typical urticarial lesions (see Fig. No. 10).

Such a contact type of sensitivity had not been suspected, as the patient was first seen in the winter. Subsequent more careful questioning revealed that the browntail moth larvae had crawled through the hayfields in large numbers during the 1940 haying season and many of them most certainly went into the hayloft with the hay. The poison from the barbed hairs of these caterpillars, in all probability produced the vesicular lesions on the shoulders and the urticarial lesions noted in the summer of 1940, as well as those observed after handling hay from the mow during the winter. Furthermore, it had been his custom twice daily to draw water from a well which was beneath a tree in the yard. Subsequent inspection showed many nests of the browntail moth in this tree and in some of the trees in the timber where he cut wood. Apparently enough of the poisonous hairs or poisonous material dropped on this patient when he was under the nests to cause an urticarial response on the skin.

It became obvious, then, that poisonous material from the browntail moth caterpillars, from the adult moth, or from the nests, when it came in contact with this patient's skin produced an immediate severe generalized urticarial response. Furthermore, it was apparent that this man must either leave his farm and change his occupation; or else an attempt must be made to desensitize him. It was decided to attempt treatment.

A number of the nests, including the young larvae, were sent to the Arlington Chemical Company to be extracted for a preparation for desensitization. In due time, a test dose of this material was obtained and produced a definite skin reaction. A treatment set was then prepared and injections at five-day intervals begun and continued through the various dilutions until the maximal dose of the most concentrated solution had been given. Soon after injections were begun, the patient reported that the urticaria was decreasing in number and severity. When exposed, he continued to break out locally but a generalized eruption did not appear. Two months after completion of the desensitization treatment, this man reported he had obtained good symptomatic relief and that the urticaria had practically disappeared.

Summary

This case is reported because it reveals an unusually high degree of skin sensitivity to the poisonous products of the browntail moth larvae. The authors failed to find any reports of this type of skin response in the literature, but they suspect such cases may not be uncommon. It seems equally important to record that a patient exhibiting the above type of allergic skin reaction to poisonous products of the browntail moth and its larvae was successfully desensitized with extract material from the nests and larvae of the browntail moth. The authors believe that even better results might be obtained were it possible to make up the desensitization extract from the full grown larvae or from barbed hairs obtained from such caterpillars. It was our impression that extracting the entire nest with young larvae probably gave too high an amount of non-essential protein and organic material.

The authors also suggest that it may be possible to prevent the above described distressing skin lesions by desensitizing susceptible individuals with injections of extracts made from the poison glands and poison hairs of the adult caterpillars. Thus far there has been no other opportunity to test out this possibility.

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2. Burgess and Baker: U. S. Dept. of Agric. Cir. 464, 1938.
3. Tyzzer, E. E.: The Pathology of the Browntail Moth Dermatitis. *J. Med. Research*, II, pps. 43-64: 1907.
4. Kephart, Cornelia F.: "The Poison Glands of the Larva of the Browntail Moth." *J. of Parasitology*, I: 1914-15. Pps. 95-104, 4 text figs.

Editorial

Urges Protests Now Against Threat to Medical Education

Journal Says Present Policies of the Armed Forces and Selective Service Will Result in an Annual Deficit of 2,000 Doctors

Declaring that medical educators and the medical profession of the country refuse to accept the responsibility for the acute shortage of medical care which will threaten this country within a few years if current regulations and policies of the Selective Service System and the armed forces in regard to medical students persist, *The Journal of the American Medical Association* for July 8 points out that the present situation will result in an annual and cumulative deficit of 2,000 physicians a year in face of new and increased demands for medical service. It advises the medical profession that now is the time to protest to the House and Senate Military Affairs committees against this blind disregard for medical care in the future. *The Journal* says:

"In January, 1944, it seemed that civilian and military needs for doctors would be met reasonably satisfactorily by the arrangement in which the 55 per cent of entering medical school classes would be provided by the Army Specialized Training Program, 25 per cent by the Navy V-12 Program and 20 per cent from civilian sources. In the past six months this program has rapidly deteriorated. Today medical educators and the medical profession of the country refuse to accept the responsibility for the acute shortage of medical care which will threaten this country within a few years if current regulations and policies persist. The responsibility must rest with the armed forces, the Selective Service System, the President and the Congress of the United States.

"In February the Army drastically curtailed the Army Specialized Training Program and has since renegotiated its contracts with medical schools to provide 28 per cent of the 1945 entering classes instead of 55 per cent, increasing to 47 per cent the numbers medical schools must obtain from civilian sources.

"In April the Selective Service System abolished all further occupational deferments of premedical and medical students not enrolled in medical schools by July 1, 1944. As a consequence, it was estimated that the entering classes of 1945 would be reduced 25 to 30 per cent.

"The threat to medical care entailed in these policies was pointed out to General Hershey, the Secretaries of War and the Navy, the President and others, with the suggestions that the situation could be met by (*a*) reinstitution of the inactive reserves by the Army and Navy, which functioned well for a year, and/or (*b*) an appropriate Selective Service adjustment, which was definitely a second best arrangement.

"The Army and Navy rejected the first alternative as an evasion of the Selective Service law, and the Selective Service System rejected the alternate proposal because of the acute need of the Army for young men. The needs for medical care were considered to be subordinate to the needs of the fighting forces.

"Alarmed at these developments, the House of Delegates of the American Medical Association, on the recommendation of the Council on Medical Education and Hospitals of the American Medical Association, passed the following resolution at its opening session June 12:

> Whereas, The present policy of the Army and the Selective Service System in preventing the enrolment of a sufficient number of qualified medical students will inevitably result in an overall shortage of qualified physicians, with imminent danger to the health and well being of our citizens; therefore be it
>
> *Resolved,* That it is imperative that immediate action be taken by the President or the Congress of the United States to correct the current drastic regulations, which result in a restriction of the number of students qualified to enter the courses of medical instruction in approved medical schools.

"This resolution was sent to the President, the Secretaries of War and the Navy, the Selective Service System and all members of the House and Senate Military Affairs committees.

"The latest measure still further jeopardizing medical education and medical care was the

passage of the Army appropriation bill by Congress June 21. This bill includes the following provision:

> Provided That no appropriation contained in this Act shall be available for any expense incident to education of persons in medicine (including veterinary) or dentistry if any expense on account of this education in such subjects was not being defrayed out of appropriations for the military establishment for the fiscal year 1944 prior to June 7, 1944. . . .

"This provision would seem to eliminate from 1946 entering medical classes the 28 per cent of places contracted for by the Army. Even if the Navy increases its quota from 25 per cent to 31 per cent, schools will be obliged to obtain 69 per cent of their students from women and physically disqualified males. Nothing even approaching this number of qualified civiiian students is available. Classes will probably be half filled in the country at large.

"Should an adjustment not be made to correct the present alarming situation, a tremendous reduction of graduates after the war will ensue. Although schools will continue the accelerated program, they will admit classes only once annually instead of every nine months. This of itself will reduce the number of graduates from the present annual average of 7,000 to 5,000. If classes can be only half filled, this number will be reduced to 2,500 graduates per year. Since 3,300 to 3,500 physicians die each year, there will result an annual and cumulative deficit of 2,000 doctors a year.

"Still further reductions in graduates and permanent damage to the 'plant' of medical education will result from some schools being forced to close their doors because of drastically curtailed enrolments. An unknown number of war casualties among medical officers will also reduce the supply of physicians.

"These reductions in medical graduates will occur in the face of new and increased demands for medical services, mainly from the civilian population, the standing army and navy, the Veterans' Administration and the liberated countries of Europe.

"Full support should be forthcoming from the medical profession for the Miller bill (H. R. 5128), with modifications, which reads:

> Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That section 5 of the Selective Training and Service Act of 1940, as amended, is amended by inserting at the end thereof a new subsection reading as follows:
>
> "(n) There shall be deferred from training and service under this Act in the land and naval forces of the United States, as necessary to the maintenance of the national health, safety, and interest, in each calendar year not less than six thousand medical students and not less than four thousand dental students. As used in this subsection the term 'medical or dental student' means (1) a person who is enrolled in, and who is pursuing a course of instruction prescribed for the degree of doctor of medicine at an accredited medical college; and a person who is enrolled in, and who is pursuing a course of instruction prescribed for the degree of doctor of dentistry at an accredited dental college; or (2) a person who is pursuing a regular course of instruction at an accredited college or university (satisfactory completion of which will make such person eligible for enrolment in an accredited medical or dental college) with the bona fide intention of entering an accredited medical or dental college and pursuing and completing the course of instruction prescribed for the degree of doctor of medicine or for the degree of doctor of dentistry."

"Protests against the blind disregard for medical care in the future should be addressed to the Senate (Senator Robert R. Reynolds, Chairman) and House (Representative Andrew J. May, Chairman) Committees on Military Affairs, the Senate Committee on Education and Labor (Senator Elbert D. Thomas, Chairman) and the House Committee on Education (Representative Graham A. Barden, Chairman). Every state medical society, medical school and medical scientific society should express itself in no uncertain terms on these developments."

As long as reliable mortality statistics for tuberculosis have been known, young women have always been more prone to die of tuberculosis than have their young brothers or older sisters. While the general death rate from tuberculosis has steadily fallen, the death rate among young women has also decreased, but at a slower rate. The fact remains that tuberculosis is prevalent enough, particularly among young women, to warrant, in the opinion of many authorities, a tuberculin test on all pregnant women. Treatment of tuberculosis has advanced so rapidly in recent years, that with early recognition of the condition in pregnancy, it is possible in many cases to bring the baby through safely with no danger to the mother.—*National Council for Mothers and Babies.*

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
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Franklin
President, Albion E. Floyd, M. D., New Sharon
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President, Philip L. Gray, M. D., South Brooksville
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Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Aroostook

The annual meeting of the Aroostook County Medical Society was held at Houlton, Maine, July 11th, 1944.

Supper at the Northland Hotel, at 7.00 P. M., was followed by a business meeting and the paper of the evening.

At the business meeting the following officers were elected for 1944-1945:

President, Clyde I. Swett, M. D., Island Falls.

Vice President, Eugene B. Griffiths, M. D., Presque Isle.

Secretary-Treasurer, Thomas G. Harvey, M. D., Mars Hill.

Delegates to the 1945 annual meeting of the Maine Medical Association: Drs. Swett and Griffiths.

Alternates: Herbert F. Kalloch, M. D., Fort Fairfield, and P. L. B. Ebbett, M. D., Houlton.

It was moved, seconded and carried that the Aroostook County Medical Society go on record as being opposed to the Prepaid Medical Care plan as outlined by a special committee of the Maine Medical Association, but would favor any plan which would improve medical care in the State of Maine.

President Faucher then introduced the speaker of the evening, Dr. P. S. Pelouze, Urologist of Philadelphia, now working for the U. S. Public Health Service. Maine is the twenty-first State Dr. Pelouze has visited in connection with research on diagnosis and treatment of Gonorrhea. Dr. Pelouze gave a very much to the point talk on this subject, with especial reference to the disease in the female, stressing manner of taking smears, danger in assuring patients that they are "cured" when a large percentage are not cured, and errors in assuming infallibility of sulfa drugs and penicillin in treatment. An ordinarily rather dry subject was made most interesting by the speaker's humor and stories.

President Faucher closed the meeting with appropriate remarks of appreciation for Dr. Pelouze's visit.

Thomas G. Harvey, M. D.,
Secretary.

Kennebec-Somerset-Waldo

A joint meeting of the Kennebec, Somerset and Waldo County Medical Societies was held at the Elmwood Hotel, Waterville, Maine, July 20th, 1944. Following dinner, at 6.30 P. M., the meeting was called to order by Thomas C. McCoy, M.D., Vice President of the Kennebec Society, in the absence of the President. It was voted to dispense with the reading of the minutes of the last meeting of these Societies, so that Dr. McCoy immediately introduced the speaker of the evening, Dr. Percy S. Pelouze, Assistant Professor of

Urology, University of Pennsylvania School of Medicine. Dr. Pelouze, who is well known for his ability as a teacher, author and lecturer gave a talk on *Gonorrhea and Its Treatment.*

By means of slides he illustrated how gonorrhea differed in the two sexes and explained why the disease is so much more serious in the female. By using the same line of reasoning he graphically told why it is dangerous to accept a few negative smears as evidence of cured gonorrhea, especially in the female, after the use of a sulfa drug or of penicillin. He likewise cautioned us to use local treatment along with the two drugs already mentioned and then to have the patient return periodically for physical check-up so that if and when the disease recurs we shall be in a position to immediately detect and treat the same.

During the general discussion there were numerous questions raised and answered.

Twenty-six members were present.

CLAIR S. BAUMAN, M. D.,
Secretary.

New Member

Oxford

Willard H. Boynton, Bethel, Maine.

Necrology

Joelle C. Hiebert, M. D., 1892-1944

Joelle C. Hiebert, M. D., 51, Superintendent of the Central Maine General Hospital, died on June 8, 1944, at the institution which he headed for thirteen years. Doctor Hiebert was educated at Tabor College and Boston University School of Medicine from which he received his degree in 1923, following which he served as House Officer at the Massachusetts Memorial Hospital (1923-24) and resident physician and superintendent of the Medical Mission Dispensary, Boston (1924-31). He was Clinical Instructor of obstetrics at Boston University (1924-31) and Instructor of Preventive Medicine and First Aid at Gordon Theological College (1929-31).

In 1931, he was appointed Superintendent of the Central Maine General Hospital which he served up to the time of his death. During this period the hospital enjoyed a rapid expansion in size of services. The Doctor was fond of referring to the hospital as the "House of Healing" and to it he devoted all his time and energy. His philosophy toward the ill may be summed up in his own phrase, "altogether for one." This he carried out in practice by mobilizing all possible assistance in the healing of every patient admitted. His interest in the sick was not limited to the walls of his own institution and he always offered his support to the development of other healing institutions, and, therefore, supported the Bingham Hospital Extension Services which to him became an absorbing interest. His broad view of medicine found fertile soil in this larger field, since he was of the conviction that better medicine in neighboring institutions would also elevate medicine in every institution. This attitude was natural to him as he came from a family of physicians. He emphasized continuing education for those interested in the care of the sick by instituting teaching clinics for the interns and visiting staffs, and well stocked libraries for doctors and nurses. He forever encouraged nurses, doctors, and interns to pursue graduate study.

He was a member of the American College of Hospital Administrators, American Hospital Association, American Protestant Hospital Association, a trustee of the New England Hospital Assembly and its President in 1941-42, a member of the Maine Hospital Association, and its President in 1937, a member of the Boston Hospital Superintendents Club, a member of the Maine Civilian Defense Committee and on the Advisory Council of the Maine State Department of Health and Welfare.

At the time of his passing he was on the Editorial Board of THE JOURNAL OF THE MAINE MEDICAL ASSOCIATION. He took an active interest in local civic activities as a member of the American Society for Control of Cancer and the Androscoggin Anti-Tuberculosis Association, as well as being a loyal and devout member of his church and many charitable institutions.

He is survived by his widow, Mrs. Susie Hiebert; three sons—Joelle, Clement, and Gordon; and two daughters, Ruth and Dorothy.

A Medical Metamorphosis—Continued from page 156

we have no moral right to try to decide such an issue in their absence. Why should we speak for them and plan for their future? They have a right to be heard and to take part in such deliberation, for it will be they who will be mostly affected, if such plans were put into operation. Who will direct this insurance business? Will there not be organized minorities who might have the ear of the Director? Naturally osteopaths, being equal partners in this proposition, might be jockeyed into position where they would hold the controlling power. When you realize that you would be taking nearly three hundred osteopaths in on even ground, if this scheme were adopted, it is too dangerous and silly to even consider, for in such partnership, it would be an admission of their equality and that they too are qualified to practice medicine. By the very nature of the contract, we would have two standards of practice, osteopaths on one side and doctors of medicine on the other. That is unworkable, unthinkable and preposterous unless you are ready and eager to sell out again to this same old crowd.

I believe that being faced with post-war health problems, it behooves each and every one of us to take inventory of these thoughts and to attempt to determine the proper action to be taken. I believe that we as physicians must carry on, not only in the post-war world, but during the remaining years of this war, a better public education program which will bring home to the public the tremendous job the medical profession has done. We must get across to them that we have evidence to believe that the American system of medicine is the finest that exists in any part of the world, and this same Public should be made aware of the fact that the administration, stimulation and continuation of our present system of American medicine will go on, if those men who are most fitted to insure its existence, namely, the physicians who have brought it to this level, continue to direct its destinies.

Emergence of the medical profession from the war in a favorable position to assume leadership in the planning of healthier civilization is inevitable. Medical research now directed towards victory will again turn to civilian problems. Battleborn technical and procedural advances will be translated into general practice, and perhaps our own local problems will seem infinitesimal. Educational, economic and socialogic problems brought into sharp focus by the war will be subjected to intensified scrutiny. Success of these efforts to better the health of the entire population will be measured by the degrees of extension of the present type of American medical care, which is admittedly the best in the world, and may it continue as such and not be disturbed by the pressure brought to bear by the bureaucratic activities in Washington.

Book Reviews

"Fertility in Men"

By: Robert Sherman Hotchkiss, B. S., M. D. Lieutenant Commander (M. C.), USNR on active service; assistant professor of urology, New York University Medical College; instructor in surgery (urology), Cornell Medical College; assistant visiting attending physician, Department of Urology, Bellevue Hospital; assistant visiting attending physician in surgery (urology), New York Hospital; chief of urological clinic, New York University Medical College Clinic.

216 pages, 95 illustrations with a foreword by Nicholson J. Eastman, M. D.

Published by J. B. Lippincott Company, Philadelphia. Price, $3.50.

Startled by the knowledge that in the past decade or two, one-third to one-half of childless marriages were occasioned by sterility of the husband, Dr. Hotchkiss "went to work" to determine, if possible, the "why" of such a condition. This book is ample evidence that his long days of research were not in vain.

His findings together with some personal conclusions and observations make up the text of this publication, which is a companion book of "Fertility in Women" also published by Lippincott.

A clinical urologist of distinction, Dr. Hotchkiss places a great emphasis on the practical details of determining and treating cases of male sterility.

"Fertility in Women"

By: Samuel L. Siegler, M. D., F. A. C. S. Attending obstetrician and gynecologist, Brooklyn Women's Hospital; attending gynecologist, Unity Hospital; assistant obstetrician and gynecologist, Greenpoint Hospital; attending sterility clinic, Greenpoint Hospital; consultant in gynecology, Rockaway Beach Hospital; Diplomate American Board of Obstetrics and Gynecology, Fellow New York Academy of Medicine; Member Society for the Study of Internal Secretions.

450 pages, 194 illustrations with foreword by Robert L. Dickinson, M. D.

Published by J. B. Lippincott Company, Philadelphia. Price, $4.50.

Long of the conviction that childless marriages constitute an individual and social problem of serious and challenging magnitude, Dr. Siegler gives to the profession this clinical analysis of a problem as old and intriguing as the world itself.

The book, released simultaneously with the companion publication, "Fertility in Men," is penned from the systematic and functional point of view. Dr. Siegler stresses the imperative need of complete cooperation and teamwork between the family doctor, the specialist and the research worker.

He points out that rapid advances in the fields of biology, chemistry, physiology and psychiatry, as they pertain to the problems of human reproduction and sex adjustments, have aided no little in detection of causes and then the treatment of impaired fertility.

The author has correlated results of innumerable experiments and, as a consequence, has conclusions of deep concern which should be of real interest and value to medical men who offer premarital counsel and early postmarital advice.

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*Presidential Address**
Maine Hospital Association, 1944

Frederick T. Hill, M. D., Waterville, Maine

I am deeply appreciative of the honor and privilege of serving as your President this past year. I came into the hospital association through the side-door, somewhat by accident, a sort of stray from the purely medical fold. Working with you has been an enjoyable experience. I have learned a good deal which, I believe, has made me a better and a more understanding physician. I am convinced that a more intimate knowledge of hospitals and their problems would be of value to our physicians generally and that the inclusion of more staff physicians in the association would benefit both the association and the physicians.

It is the custom in most medical associations for the President to give an address at the annual meeting. I think this is a good custom. It provides an occasion for reporting what you think you have accomplished during the year and for presenting alibis for that which you have left undone. Usually on taking office one reviews the splendid work of his predecessors and only hopes to continue it without too much of a let-down. But new situations arise, fresh problems develop and opportunity leads to opportunity. Soon one is embarked on a new, and what seems a necessary program which bids fair to outlast his year. So one is naturally led to offering suggestions for the Future, which, fortunately perhaps, are not given too much consideration by those who follow him.

My predecessors have builded well. The Maine Hospital Association is in good condition. All credit should go to Dr. Hiebert, Dr. Brown, Dr. Craig, Mr. Spear, and our Secretary, Miss Fisher, for what has been accomplished.

Viewing the immediate situation, it seemed to me that greater Trustee representation, through personal memberships, was an absolute necessity. I have always felt that the hospital association, composed as it is of physicians, nurses and laymen, all interested in hospital work, was potentially the strongest organization concerned with health problems. Now we are facing great economic changes. In Washington we are confronted by a threat to our whole voluntary hospital system in certain proposed legislation. In our own State we should revise our method of financing the hospitaliza-

* Read at the Annual Meeting of the Maine Hospital Association, Waterville, Maine, June 23, 1944.

tion of the indigent and the needy. The system we have been working under simply grew like Topsy and fails to accomplish what it should, both in providing proper care to the patient and adequate support to the hospital; while the important field of Preventive Medicine has been barely scratched. I am happy to say that in Mr. Page, Commissioner of Health and Welfare, we have a progressive and far-sighted official who understands this problem and is anxious to correct it. Our Association must be actively concerned in all of this, but the influence we exert will be only proportionate to our strength. Hospital Trustees are, by nature, socially-minded people, interested in these very problems. They are people of influence in their communities and in the State. The building up of personal memberships from this Trustee group would immeasurably strengthen our organization and, at the same time, develop better trustees. We would have the benefit of their influence and prestige, their advice and counsel; and they would become better informed and equipped to serve their individual hospitals. With this idea in mind we have endeavored to increase our personal membership and it is with some degree of pride that I report 48 new personal members, a gain of 107% over last year. Four hospitals have 100% trustee membership.

It has been only natural that the larger hospitals have rather dominated the State Association. Their administrators and trustees were more conversant with the broader aspects of hospital work, and naturally and properly assumed the leadership. But I had a suspicion, since confirmed, at least to my mind, that the smaller community hospital did not feel itself always an active part of the Association. While the work done in each such hospital might be small in comparison to the larger institutions, in the aggregate, these community hospitals provide the care for the larger part of our people. And I firmly believe that the community hospital must become, in the very near Future, the Health Center for that community and its surrounding area, concerned with the broader phases of Preventive Medicine, and of Health Education; instead of being merely a medical repair shop, or service station. This is the solution that I see for this problem of caring for the health of our people. Then it becomes increasingly necessary for our Association to be truly a State Association which should represent and function for each member hospital. With this objective in mind we have undertaken to organize the hospitals of the State into Regional Conferences, so located as to make for easy travelling conditions, that they might meet together periodically, discuss their common problems and coöperate in their solution. The State has been divided into six such conferences. Each conference has elected its chairman and secretary and has made plans for future meetings. This idea has possibilities. We can all profit by coöperation. I would like to see it made a permanent and official part of our organization, with the several chairmen, elected by and representing the hospitals in their regional conferences, acting as an advisory council to the officers of the State Association.

The need for a modern and more uniform system of accounting in our hospitals has been recognized for a long time. There has been such variation in the reported costs for patients' care due to the different systems, and often lack of system, that it has been impossible for the State Department of Health and Welfare to arrive at anywhere near an equitable plan for reimbursement. It is out of the question to expect relief for the hospitals in caring for the State Aid patients until accurate statistics are available. I would recommend the adoption by our hospitals of the uniform system of accounting of the American Hospital Association. Sound business procedure should demand this. I have good reason to believe that an expert Consulting Accountant will be available through one of the Foundations, should our hospitals manifest a desire for this service.

At the suggestion of State Departments of Education and of Health and Welfare a professional advisory committee, composed of representatives of the Maine Municipal Officers' Association, Maine Medical Association, Maine Nurses' Association and Maine Hospital Association, has been established to consider the various public aid programs involving hospitalization. This is a step in the right direction and I feel that a great deal will be accomplished in establishing a simpler and more uniform system of providing hospitalization under these programs.

Continued on page 188

*Some Intangibles Which Effect Hospital Administration**

Joseph C. Doane, M. D., Medical Director, Jewish Hospital, Philadelphia
Professor of Clinical Medicine, Temple University School of Medicine, Philadelphia

Three decades have wrought great changes in hospital work. When first entrusted with the supervision of a large institution, I, as has been the case with many others, found myself at the Director's desk by the Grace of God and a curious turn of the wheels of fortune. I was highly endowed with a desire to succeed — a hope that I would find the requirements of the position not too disproportionate to my meager administrative experience. I grew by the process of trial and error — by somehow learning early that the hospital is a machine which, if let alone, will long run by simply applying now and then a feeble push here and there. Many ineffective administrators have learned this fact before and since. It is often quite a time consuming process for directors to be sure that their executive officer has not permanently adopted this policy. I early became convinced that it is much easier to keep the mechanical equipment of the institution from breaking down than to maintain a highly efficient and continually smooth functioning personnel. The parts of a motor can be selected from a shelf or a catalogue — it smokes and hisses when its grease cups are dry, and it can be dismantled for inspection when occasion arises. But (worse luck) the brain of a conniving hospital employee cannot be removed for inspection to learn the cause of a disloyal or an indiscreet act. Sudden death from an employment angle should meet those who coyly remind us that a duty was not performed because "there is a war on."

As I aged in hospital work, I was given the opportunity to view first hand the functionings of institutions of all types and many sizes. I saw many similarities in hospitals as a class — in superintendents — in chief nurses — in dietitians and doctors. I saw the practical and inevitable results of wise and careful handling of monies and men. I saw the sordid effects of the lack of wisdom — of forethought — of the presence of what you in Maine and my ancestors from Cape Cod have called "hoss sense."

I have observed the results in lack of good care for the sick, of the presence of the belief that a good hospital is one which has the most splendid and resplendent architecture. Paraphrasing Richard Lovelace, we may assert that stone walls do not a hospital make, any more than they make a prison. In the golden insane twenties, hospitals endeavored to demonstrate which could apply the most gilt to their walls and towers. A wild orgy of building — of expansion occurred. Parenthetically with all this, salaries and wages remained at or near a starvation level, so that it took a second World War to secure any real degree of financial justice for those in the lower institutional brackets. And so as I have travelled the corridors which opened because of my interest in hospitals and their patients, I have endeavored to make a kind of mental tabulation of the types of institutions which I have studied or even more casually known. And in the case of those of superior performance I endeavored to learn whether only hospitals with large endowments, those with traditions brought by age, those with closed staffs or open staffs, those which were allied with medical schools, those in the city or those in the country, were particularly distinguished in accomplishing the highest aims of modern institutional medical practice. I have endeavored to learn why more institutions do not, as expressed by the late Dr. Henry Van Dyke, insist that their physicians employ tonics with wisdom, sedatives with discretion and narcotics with parsimony. Why oftener in hospitals, persons and personalities never predominate over principles, while all are learning and none ever encircle all knowledge. Certainly maudlin ostentatious sympathy for the sick never should replace a calm scientific attack on disease.

There is the hospital whose Board of Trustees and perhaps the superintendent by contagion or coercion measure success in terms of

* Read at the Annual Meeting of the Maine Hospital Association, Waterville, Maine, June 23, 1944.

black or red ink. Unfortunately, today there appears to be a strong trend toward efforts to make the voluntary hospital pay for itself. This is, of course, not in accordance with the hospital's best traditions. Moreover, when such is the case, the Board of Directors would do well to carefully review the functioning of their institution so as to be certain that some improper alteration in its aims has not taken place, that tangibles have not gained temporary prominence over things spiritual. To be sure there must be buildings, machinery, operating room tables, instruments, drugs, dollar bills, food, gauze, people, paper and potatoes. But these are the physical tangibles, the touchables, the things that we can weigh, handle, see, hear or taste. These we may buy, use, discard or discharge at will. No, we must conclude that neither a balanced budget or an unbalanced budget nor deluxe menus, air conditioning, the morning paper at the door, the rose on the breakfast tray or the hospital monthly magazine guarantee safe medical care. These tangibles are but the mute evidence, the shadow of the intangibles, and are not the true substance of good hospital service. Let us not mistake the shadow for the substance. This is a fatal error. No, we certainly may conclude that neither in town or city, in age or in youth, in university or without, in poverty or in wealth is to be found the open sesame, the lodestone of institutional success. Success in my opinion, lies in people, in their sense of fair play, in their vision, their intelligence and in their unceasing dissatisfaction in present accomplishments. Success lies in the construction by the community of the hospital spiritual.

What further intangibles affect our future? Surely a good organization is of the greatest importance. Therein will be found sound board policies where men and women serve not for profit of any sort, where policy making is the aim and never administration, where personalities and politics are anathema. Such a board will provide a blueprint of organization to be placed on the wall of every departmental office. It will see that hospital workers are well housed and well paid. It will provide for carefully worked out rules to govern the activities of all. But the individual traits mentioned above and described below are not peculiar to any one hospital worker. While they may be possessed to a greater degree by one than by another, they must be possessed in the fullest measure by the hospital superintendent.

Capability, training, dignity—these three, the greatest of which is difficult to name. The superintendent must have delved deeply into the book of human psychology. He must know what character changes result when fear, despair and pain are inflicted upon men and women. He must realize the necessity of throwing strong safeguards about the surgical patient, the tonsil clinic, the out-patient department, so that while physical good is being accomplished, a greater psychologic trauma is avoided. He must know concerning the depth and the travail of human minds when death in a family member approaches. He should provide every physical comfort to those who must await the inevitable. He wears about himself an invisible cloak of professional dignity. He listens with judicial patience to complaints, is always friendly, but never familiar. Just as Oliver Wendell Holmes in an address to a Harvard Graduating Class warned, "That the physician must never enter the boudoir of suffering loveliness reminiscent of the odors of an extinguished meerschaum," so the superintendent who is tempted to walk the wards of his hospital accompanied by a pipe or a lighted cigarette violates thereby the rules of good judgment and ethical conduct.

And then there is graciousness which is but another name for good breeding, courtesy and consideration for others. One does not need to agree with everyone—to be a "yes"—superintendent in order to be gracious. Thomas B. Aldrich spoke of the man who was gracious to all, to none subservient — without offense he spoke the word he meant. Salemen who visit our hospitals may be a source of much information. 'Tis but common sense to be courteous to them. Graciousness begets reactions in kind. The human mirror of personal relationships with others still functions as of yore. When one sees round about him in these strenuous times hurry and discourtesy and thoughtlessness, does not the hospital have a direct challenge to create within itself an atmosphere of calmness and good breeding which is in direct contrast to that experienced in stores, street cars or on the street?

Then there is tact which is only doing and

saying the right thing at the right time. To discuss in the presence of an emaciated convalescent typhoid patient the details of a fine Christmas dinner or to annoy a tired surgeon with matters that will wait decision, is hardly tactful. To send an irritable, yet good worker on a vacation rather than to verbally castigate her is but an act of good judgment.

Adaptability is akin to tact and good judgment. Diogenes Laertus spoke of the man who was capable of adapting himself to place and time and person and of playing his part appropriately whatever the circumstance. Another Roman philospher said, "The wise man does no wrong in changing his habits with the times." And so the hospital in these new days must be capable of revising its policies to meet new and most unexpected developments.

Discipline to many is a fearsome word. It suggests punishment and unhappiness. It may be autocratic, military or coöperative in type. It may be based upon an exemplification of a desire to possess a full understanding of the motives of others or it may be unreasoning and oppressive. Surely superintendents of hospitals should clearly distinguish between the insistance on right principles and the insidious insertion of personalities into a problem. Woe be to that administrator who fails to differentiate between the need for encouragement or for criticism, between the time to punish or to praise. To teach, to organize, to deputize and then to continually supervise is a fine maxim of procedure. Once we have picked department heads we must not interfere with them. We must support them in public as long as possible. We must fearlessly discharge them when the good of patients dictates. To play the part of detective or to encourage tale-bearers is a bad policy. The most spirited and serviceable of horses may be ruined by a driver who continually snaps the whip.

Humility is a golden quality in all those who treat the sick. It has always been a mystery to me how any hospital worker, high or low, could be egotistical in the presence of life and death. W. S. Gilbert remarked on this point, "You've no idea what opinion I have of myself and how little I deserve it." Good staff physicians are inclined to believe that knowledge and skill are often so futile in the presence of the mysteries of life that they should stand figuratively with bared heads — abashed at their own ignorance.

Ethics is a word much abused. To me ethics means but the practice of the Golden Rule. It signifies but the playing of the game according to its rules. It forbids kicking your ball out of the sand pit because nobody is looking. Demanding donations from salesmen under threat of refusing further business, informing a competitor of another's bid, secretly cutting rates, the practice of anything but the strictest honesty in published hospital reports or the concealing from the rest of the field the results of research, are far from ethical practices.

As to the superintendent's relationship to himself, it may be said that he must possess a burning ambition for intellectual improvement. Satisfaction with an institution's accomplishments is fatal. A sense of humor is lifesaving. Some believe that the superintendent's wife, or shall we include her husband, should content herself or himself with family duties and should know but little concerning hospital matters. When the parson's helpmate endeavors to settle the affairs of the choir, a declaration of war usually follows. Alcohol and hospital administration make almost as poisonous a mixture as do gasoline and intoxicants. The acceptance of gifts from supply houses by the superintendent is to be avoided. "Timeo Danaos et Dona Ferentes," which is to say that even today the Greeks sometimes bear gifts for ulterior reasons. The entertainment of members of the hospital family by the superintendent, unless all of the group are so favored, is not wise. The hospital superintendent therefor, is a man or a woman capable of maintaining the highest and finest traditions of his or her profession in the community. Surely an abiding faith in the future, a respect for all matters religious and above all, an ability to lead a community in thought and in act, are essential ingredients in the character of him or her who undertakes to direct a safe and humane modern hospital. Alan Dafoe in describing the wonders of the autumn skies filled with migrating birds remarked, "In our bitterly confused times this much can we say with surety—the ancient unknowable harmonies still endure." So we can conclude that in the unknowable, unfathomed depths of human character, great and unsuspected good is usually to be found. To search for it, find it and use it wisely is the goal of the good administrator.

Editorials

1945 Annual Session
To Be Held at the Poland Spring House

The Council of the Maine Medical Association, in session August 6, 1944, at Dr. E. E. Holt's cottage, So. Portland, Maine, voted to hold the 92nd annual session of the Association either at the Poland Spring House or at The Sam O set. In-as-much as the Poland Spring House had first choice, arrangements have been completed to hold the meeting there on Sunday, Monday, and Tuesday, June 24, 25, and 26, 1945.

Harvey C. Bundy, M. D., of Milo, Maine, Chairman of the Scientific Committee, will be in charge of arrangements for the Scientific Program. Suggestions relative to this meeting will be gratefully received and may be sent to this office or to Doctor Bundy.

Proceedings—91st Annual Session
House of Delegates

Publication of the Proceedings of the meetings of the House of Delegates, of the Maine Medical Association, held during the 91st annual session, at Rockland, Maine, June 25, 26, and 27, 1944, will start in this issue of the Journal.

The Budget for 1944-1945, as recommended by the Council and approved by the House of Delegates; the report of Thomas A. Foster, M. D., of Portland, Delegate to the American Medical Association, and the reports of the delegates to the New England Medical Societies, will be included in that portion of the report published in this issue.

Future issues will bring to you the discussions relative to Prepaid Medical Care Plans, the present Venereal Disease Law, and Farm Security Administration; the election of a Delegate to the American Medical Association for two years; election of Councilors for the Third and Fourth Councilor Districts, and many other items of interest.

It has been necessary to delete portions of this report because the paper situation necessitates careful conservation of space, but the complete report is on file in this office and is available to any member of the Association.

Journal Names Chief Problems of Postwar Medical Education
Early Demobilization of Faculty Members, Further Education for Discharged Medical Officers, Improved Curriculums Needed

Improvements of curriculums in medical schools to prepare the student more adequately for the problems of today, the early release from the armed forces during the period of demobilization of physicians on medical school faculties so as to restore the quality of medical instruction to a higher level as soon as possible, and the provision of further education for discharged medical officers are the chief challenges facing medical education today, *The Journal of the American Medical Association* for August 19 points out. *The Journal* says:

"The medical schools and their faculties have met the challenge of wartime conditions cred-

itably, teaching more students in less time than formerly in the face of greatly depleted numbers of instructors. The devotion of faculty members who carried on the increased work under adverse conditions is highly commendable. In the period of demobilization to come, special consideration should be given to the preferential early release of physicians on medical school faculties so as to restore the quality of medical instruction to a higher level as soon as possible.

"The studies carried out by the Committee on Post-war Medical Service . . . indicate the magnitude of the problem of providing further education for discharged medical officers. There were requests for additional postwar training from 796 of 1,000 officers replying to a questionnaire. Nearly 34 per cent requested courses of less than six months' duration. Nearly 46 per cent desired further work in hospitals for six months to three or more years. Provision of the requisite additional educational opportunities will require the concerted efforts of internship and residency hospitals, medical schools, medical societies, specialty boards and others. We owe this service to those medical officers whose education was interrupted by the war.

"Numerous problems in undergraduate medical education also must be met. Wartime experiences in medical care for the armed forces and for civilians have accentuated the growing importance of certain expanding fields of medicine. Notable among these are neuro-psychiatry, public health, industrial health, physical medicine and tropical medicine. . . .

"More material cannot be added to the undergraduate curriculum unless other subject matter is withdrawn. At many points a reduction of the content of 'courses' not only would be possible but would improve the educational program. Vested interests of certain departments or faculty members, established by outworn tradition or the aggressive capturing of curricular time, must not be permitted to stand in the way of an improved curriculum which will more adequately prepare the student for the problems of today in medicine."

In the same issue of *The Journal* is the annual compilation of information on medical education in the United States and Canada, prepared by the Association's Council on Medical Education and Hospitals.

Combine Immunization Against Whooping Cough, Diphtheria

Studies Show That Infants Can Be Immunized Successfully Against the Two Diseases at the Same Time, Investigators Say

Studies show that infants can be immunized successfully against diphtheria and whooping cough at the same time, Louis W. Sauer, M. D.; Winston H. Tucker, M. D., and Eva Markley, R. N., Evanston, Ill., report in *The Journal of the American Medical Association* for August 5. This finding is important in view of the increasing number of immunization procedures required in early life to protect against various disease hazards.

"The routine injection of diphtheria toxoid (diphtheria toxin rendered nontoxic by incubation with formaldehyde) during the latter part of the first year of life," the three investigators explain, "has almost completely eliminated diphtheria in most localities; and, during the time that infants after the age of 7 months have been injected with potent pertussis vaccine (the killed whooping cough bacteria), whooping cough morbidity and mortality have decreased at an encouraging rate.

"Because diphtheria and whooping cough are most prevalent and serious in the first years of life, it seemed logical that immunization against the two diseases should be attempted at the same time by the injection of mixtures of diphtheria toxoid and potent pertussis vaccine. . . ."

They started their investigations in 1938. The present report is based on the findings from injections given 649 infants at the Evanston Health Department Immunization Clinic and at St. Vincent's Infant and Maternity Hospital, Chicago. All were more than 7

Continued on page 186

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, Edward Thegen, M. D., Bucksport

Kennebec
President, Clarence R. McLaughlin, M. D., Gardiner
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Abbott J. Fuller, M. D., Pemaquid

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, Pierre B. Aucoin, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Manning C. Moulton, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Lester F. Norris, M. D., Madison
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Waldron L. Morse, M. D., Springvale
Secretary, C. W. Kinghorn, M. D., Kittery

Notices

Prescriptions for Heavy Cream

The War Food Administration has announced that beginning August 1st, 1944, all prescriptions for heavy cream (in excess of 19% butter fat) must be approved by a local public health officer or the Secretary of a County Medical Society.

Amendment 2 to War Food Order 13, emanating from the Office of Distribution of the War Food Administration.

State of Maine
Board of Registration of Medicine

Adam P. Leighton, M. D., Portland, Secretary.

List of Physicians Licensed in Augusta, Maine, July 6, 1944.

Through Examination

Richard Linwood Chasse, M. D., Cooper Hospital, Camden, N. J.

James Payson Dixon, Jr., M. D., 2nd Medical Service, Boston City Hospital, Boston, Mass.

James Patrick Fleming, Jr., M. D., 321 East 42nd St., New York, N. Y.

Robert Orcutt Kellogg, Jr., M. D., Lincoln Hospital, Bronx, New York.

Herbert Levere Miller, M. D., 489 State Street, Bangor, Maine.

Laszlo Ormandy, M. D., 116 Seaman Ave., New York, N. Y.

Linwood Manning Rowe, M. D., 250 Penobscot St., Rumford, Maine.

Through Reciprocity

Jerome Webster Bergmann, M. D., Oakland, N. J.

Willard H. Boynton, M. D., Bethel, Maine.

Albert S. Crawford, M. D., East Blue Hill, Maine.

John Edwin Robinson, M. D., 331 Veranda St., Portland, Maine.

Christine Waterhouse, M. D., Kennebunk, Maine.

The Physician's Importance in War and Peace

To memorialize the medical profession's "skill and courage and devotion beyond the call of duty" is the purpose of the new prize-contest recently announced by the American Physicians Art Association.

The contest is open to all physicians, both civilian and military, who are members of the A. P. A. A. The prizes are sufficiently important to attract some very fine art in all of the principal media, including oil, water color, sculpture, and photography.

For full details, write to the Association's Secretary, Dr. F. H. Redewill, Flood Building, San Francisco, California. Also pass this information on to your physician-artist friends, both civilian and military.

Maine Medico-Legal Society

The annual meeting of the Maine Medico-Legal Society was held at the Sam O set Hotel, Rockland, June 27th, 1944, President D. M. Stewart, M. D., of South Paris, presiding.

The reports of the Secretary and Treasurer were read and accepted.

It was voted that the Executive Committee be authorized to act for the Society until the next meeting; that all new Medical Examiners and County Attorneys and assistants be elected to membership; that Chief Justice Guy H. Sturgis be elected to honorary membership; that the matter of Medical Examiner fees, especially the mileage fee, be taken up by the Executive Committee with the purpose of proposing some action to the next Legislature.

Arch H. Morrell, M. D., Augusta, presented two interesting cases of Asphyxia.

W. W. Waters, M. D., Boston, discussed past and future Medico-Legal Seminars given in Boston by the Medico-Legal Department, Harvard University, including the one to be given this year October 2-7, 1944.

All who can go are urged to attend the Session on October 4th, to which all Medical Examiners, County Attorneys and police officers are invited.

The principal address, given by Chief Justice Guy H. Sturgis, of Portland, was both instructive and entertaining.

It was much enjoyed by all the members, who hope the Judge will be with us again before long.

Officers for 1944-1945 were elected as follows:

President—Benjamin Butler, County Attorney, Franklin County, Farmington.

Vice President—Roland L. McKay, M. D., Augusta.

Treasurer—Walter S. Stinchfield, M. D., Skowhegan.

Secretary—George L. Pratt, M. D., Farmington.

George L. Pratt, M. D., *Secretary.*

Medicolegal Conference and Seminar

The Massachusetts Medicolegal Society in conjunction with the medicolegal departments of Harvard, Boston University and Tufts medical schools will hold an all-day conference at the Mallory Institute of Pathology, Boston City Hospital, October 4. It will include lectures, demonstrations and informal discussions concerning many subjects in legal medicine, particularly stressing some of the more recent procedures. This meeting will be open to any registered physician, lawyer, police official, senior medical student or other medical investigator who may be interested and care to register. No limit in number has been made. There will be no fee for registration. While advance application is not essential, it would be helpful to those arranging the conference if notice of intention to attend is sent prior to October 1 to Dr. William H. Watters, department of legal medicine, Harvard Medical School, Boston.——The Harvard Medical School, Courses for Graduates, with the coöperation of the medical schools of Boston University and Tufts College, offers a seminar in legal medicine, October 2-7, planned particularly for medical examiners and coroners physicians but open to any other suitable graduate of an approved medical school. The course will be practical rather than theoretical and will consist of necropsy demonstrations, technic and interpretation of laboratory tests, study of the day by day cases of a medical examiner, round table conferences and the many subjects now included in the widening field of legal medicine. In order that each participant may receive the maximum benefit, the enrolment has been limited to fifteen. For the seminar the fee is $25. Application should be made on or before October 1 to Harvard Medical School, Courses for Graduates, 25 Shattuck Street, Boston 15.

Necrology

William W. Bolster, M. D., 1873-1944

William Wheeler Bolster, M. D., passed along August 11, 1944. Born in Mexico, Maine, most of his early life he passed in Auburn. He graduated from Bates College in '95. He was always keenly interested in physical fitness and throughout his undergraduate days was a star athlete. His interest in methods of body-building brought him into close contact with Dr. Whittier of Bowdoin and Dr. Sargent of Harvard. He greatly admired both, and both became his enduring friends. For several years following his graduation he was in charge of the Department of Physical Education at Bates. Naturally he gravitated into the study of medicine, graduating from the Maine Medical School in 1908. For many years as interne, adjunct, major surgeon, he was a member of the Surgical Staff of the Central Maine General Hospital. For more than a quarter of a century he served as house physician at Poland Spring. He was a member of the American Medical Association, the Maine Medical Association, and the Androscoggin County Medical Society.

As one might expect, his interest in the creatures of the great out-of-doors was keen, his knowledge accurate. He knew the woods, the lakes, the streams.

The writer was an intimate friend of Dr. Bolster for more than half a century. For many years he was a neighbor. He knows how absolutely straight thinking and direct and kindly Doctor Bolster was; how interested in people and their activities; how square in his dealings. College dorm, athletic field, operating room, his home, my home, abounding health, a little sickness: fifty-four years. I think I came to know the manner of man he was. William Wheeler Bolster was a man's man, quiet; unassuming. He couldn't tell one tune from another and he couldn't spell. He was never a "yes, yes" man. He carried no chip on his shoulder, but he was not afraid of a fight. He was a careful and honest physician and surgeon, a charming companion, a devoted friend. Best of all, Bill Bolster was white.

Proceedings

NINETY-FIRST ANNUAL SESSION

Maine Medical Association

ROCKLAND, MAINE

JUNE 25, 26, 27, 1944

FIRST MEETING OF THE HOUSE OF DELEGATES, JUNE 25, 1944

The first meeting of the House of Delegates of the Maine Medical Association was held at The Sam O set, Rockland, Maine, on Sunday afternoon, June 25, 1944, at four-thirty o'clock, with R. V. N. Bliss, M.D., of Blue Hill, President-Elect, presiding.

CHAIRMAN BLISS: The meeting will please come to order. We will first have a roll call by the Secretary.

(Secretary Frederick R. Carter then called the roll and the following delegates responded:)

First District

Cumberland:—C. Earle Richardson, M. D., Brunswick; Oscar R. Johnson, M. D., Portland; Joseph E. Porter, M. D., Portland; Isaac M. Webber, M. D., Portland; Theodore C. Bramhall, M. D., Portland.

York:—James H. MacDonald, M. D., Kennebunk; Charles W. Kinghorn, M. D., Kittery.

Second District

Androscoggin:—Ralph A. Goodwin, M. D., Auburn; William H. Chaffers, M. D., Lewiston; Albert W. Plummer, M. D., Lisbon Falls.

Franklin:—George L. Pratt, M. D., Farmington.

Oxford:—Harold W. Stanwood, M. D., Rumford; Albert P. Royal, M. D., Rumford.

Third District

Knox:—C. Harold Jameson, M. D., Rockland; James Carswell, Jr., M. D., Camden.

Lincoln-Sagadahoc:—James W. Laughlin, M. D., Newcastle; Warren E. Kershner, M. D., Bath.

Fourth District

Kennebec:—Herbert R. Kobes, M. D., Augusta.

Somerset:—Walter S. Stinchfield, M. D., Skowhegan.

Waldo:—Carl H. Stevens, M. D., Belfast.

Sixth District

Aroostook:—Francois J. Faucher, M. D., Grand Isle; Clyde I. Swett, M. D., Island Falls.

Penobscot:—LeRoy H. Smith, M. D., Winterport; Samuel S. Silsby, M. D., Bangor; Ernest T. Young, M. D., Millinocket.

Piscataquis:—Ralph C. Stuart, M. D., Guilford.

CHAIRMAN BLISS: A quorum is present, so we shall go on with the business of the meeting. First on the program is the appointment of a Reference Committee. I appoint Drs. Forrest B. Ames, John O. Piper, and P. B. L. Ebbett.

The next order of business is the appointment of a Nominating Committee, consisting of one delegate from each Councilor District. I appoint Drs. Willard H. Bunker of Calais,* Oscar R. Johnson of Portland, Harold E. Stanwood of Rumford, C. Harold Jameson of Rockland, Walter E. Stinchfield of Skowhegan, and Samuel S. Silsby of Bangor; Dr. Jameson will serve as Chairman of this Committee.

We shall now have a report of the Council for 1943 and 1944 by Dr. John O. Piper, of Waterville, Chairman of the Council.

(Dr. Piper then read the report of the Council for 1943 and 1944 which is on file in the Portland office.)

CHAIRMAN BLISS: It is in order now to move to accept or reject the report just made by Dr. Piper on the work of the Council for the year.

DR. OSCAR R. JOHNSON, Portland: I move that the report of the Council as just read be accepted.

This motion was duly seconded and was carried.

CHAIRMAN BLISS: Next is the presentation of the 1944-1945 budget as recommended by the Council at a meeting held this morning, which will be given by the Chairman of the Council, Dr. Piper.

(Dr. Piper then read the following recommended budget.)

The Council, in session this morning, voted that the following Budget for 1944-45, be approved for presentation at the First Meeting of the House of Delegates:

President's Expenses,	$ 300.00
Salaries:	
Secretary-Treasurer-Editor,	2,200.00
Assistant Secretary,	2,000.00
Office Expenses,	1,000.00
Committees:	
Medical Advisory,	500.00
Graduate Education,	100.00
Special,	100.00
State Delegates and Council,	250.00
Delegate, A. M. A. Annual Session,	250.00
Annual Session,	100.00
Appropriation to JOURNAL for expenses not covered by advertising,	500.00
Total,	$7,300.00

CHAIRMAN BLISS: This suggestion of an appropriation is not materially different from that of last year. Will some one make a motion to accept or reject it?

DR. JOHNSON: I move the acceptance of the recommended budget as read.

This motion was duly seconded and was carried.

CHAIRMAN BLISS: We shall now be glad to listen to the report of the Delegate to the American Medical Association, Dr. Thomas A. Foster.

DR. THOMAS A. FOSTER, Portland: The 97th meeting, House of Delegates was called to order—Monday, June 12, 1944, at the Palmer House, Chicago. Dr.

* Dr. P. L. B. Ebbett, of Houlton, was appointed a member of the Nominating Committee in place of Dr. Bunker who was unable to attend this meeting.

H. H. Shoulders, Speaker of the House, presiding. A quorum of 159 registered for the first morning session, and the delegates listened to reports of officers and committees. Dr. West reported that the associations official membership was 124,452 on April 1, 1944. Maine had recorded in the A. M. A. Directory, 1,011 physicians in State, April, 1944—of these, 738 were members of County Societies—348 only are *Fellows* of the A. M. A.

The Treasurer, Dr. Josiah J. Moore, reported that income from all sources was larger than any other year. The net gain of $718,873.76 was larger than 1942 by $388,458.42.

The expenditure was less than usual. $30,875.61 less than 1943. Reduction in legal expenses, paper, and salaries were the largest items producing the reduction in expenses. Ordinarily, new machinery, equipment, and supplies, would have been purchased. And the Trustees set aside the sum of $300,000.00 for this purpose when materials are available. Group life insurance and retirement annuities for employees was established by the Trustees. The full report of The Board of Trustees is 127 pages long, is published in a Hand Book which will be left with the Secretary of State Association for personal use by any members who wish to have detailed information. This report will bring to you some of the significant conclusions. The circulation of the *Journal* was larger than ever before as was income received from subscriptions and advertising space. There were 108,453 names on the *Journal* mailing list of December 31, 1943. In Maine, about 50% of the doctors listed, receive the A. M. A. *Journal*. The nine special scientific journals published by the Association were maintained and *War Medicine* was made a monthly periodical instead of bi-monthly. *Hygeia* prospered—having a net circulation per month of 115,846 copies.

Now a few words about the work of *Councils*. COUNCIL ON PHARMACY AND THERAPEUTICS has maintained its high standards and has enjoyed coöperation with the American Pharmaceutical Association and several other associations and societies to promote helpful understanding of problems of material interest.

JUDICIAL COUNCIL called attention to the fact that those of our profession who are now in war service will be coming back home and will return to a shattered clientele who have drifted away or who of necessity have been treated by physicians remaining at home and quoted from Principals of Medical Ethics —in part as follows:—Section 8, of Chapter 3, Art. 4. "Where a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter."

COUNCIL ON MEDICAL EDUCATION AND HOSPITALS—The council reported on problems relating to the War-Time program of medical and premedical education and house officer training especially. Approximately 3,000 medical faculty members are in the armed forces. There has been a serious difficulty in maintaining adequate educational standards. And there is considerable doubt whether Selective Service will provide for deferment of enough civilian students, who added to the students from A-12 (A. S. T. P.) and V-12 will furnish a quota sufficient to meet demands in the near future. Dr. Lahey spoke on the situation and stressed the seriousness of it and urged united and combined effort to convince the authorities that the civilian population would need physicians well trained. The Council agreed to a 9-9-9 Program for house officers. Nine months for all—maximum ⅓ deferment for 2nd 9 months—as assistant residents and ½ assistant residents may be deferred for 3rd 9 months as residents. And the Council is making plans to send a questionnaire to every Medical Officer in the Army, Navy, and U. S. P. H. Service with questions about future plans.

COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS—The Chairman of the Council made a lengthy report. It stated clearly that it approved Voluntary prepayment medical service plans under the control of the State and County Medical Societies. And that it opposed compulsory health insurances. It recommended that the House of Delegates oppose unionization of Hospital Employees. The central office of this council is to be located in the office building of the A. M. A. in Chicago, Illinois.

It has requested each State association to designate an existing committee or create a new Committee, to function with the Council on the State Level. It asked the Trustees to appropriate Funds for establishing in Washington, under auspices of the Council, an office of economic research. The Board of Trustees approved making a survey of the situation.

WAR PARTICIPATION COMMITTEE—Urged formation in every State of a Committee under this same title to work with the National Council. Twenty-six States have formed committees.

The Councils, Bureaus, and Committees of your National Association work loyally and long for the best interests of the members. It gives a member who is privileged to hear the reports a feeling of gratitude and assurance.

Many resolutions were presented, some were approved by the delegates, some were not approved. Those approved included one to ask for a transfer of the E. M. I. C. program from the Children's Bureau to the Department of U. S. Public Health Service; another recommended that all programs pertaining to Public Health should be incorporated under a single Bureau of Public Health. Another recommended a conference with interested agencies to review training for nurses with a view toward establishing different categories of trained nurses at a National level, another, to prepare for care and rehabilitation of returning soldiers. Allow me to say here that the Maine Hospital Association under the leadership of Dr. Frederick T. Hill has held a meeting to organize for this work and has thereby "jumped the gun." A resolution to have a special committee as recommended by President Herman L. Kretschmer, to study the psychiatric conditions arising during the present crisis both in civilians and returned soldiers was approved and, a committee, also recommended by Dr. Kretschmer, to study the teaching of Drug Therapy and prescription writing was approved.

In executive session resolutions pertaining to the policies of administration officers had a hearing. California took the limelight with a resolution to promote the Secretary, Dr. Olin West, to the position of Secretary Emeritus for life and to replace the editor of the *Journal*. This resolution brought up a number of delegates to speak in behalf of the good work of the association and the abilities of both the Secretary and Editor. Motion for a standing vote was seconded and carried. The vote was overwhelmingly against the resolution.

In the final session, Dr. Roger I. Lee, after 10 years faithful service as a Trustee was unanimously elected as President-Elect. Dr. L. H. Bauer of Hempstead, Long Island, was elected a trustee to succeed Dr. Lee. Six members were elected to the important new council on Medical Service and Public Relations as follows: Dr. John H. Fitzgibbon, Oregon; Dr. James R. McVay, Missouri; Dr. Thomas A. McGoldrick, New York; Dr. Edward J. McCormick, Ohio; Dr. Alfred W. Adson, Minnesota; Dr. W. S. Leathers, Tennessee. Atlantic City was selected as the meeting place for 1947 at which meeting the A. M. A. will celebrate its 100th anniversary.

Many distinguished members appeared before the meeting—Dr. Frank Leahy called attention to the serious shortage of civilian doctors and reported that he had talked with General Hershey, the Surgeon General of Army, Navy, and Public Health Service, also Mr. Byrnes. He was told that the Army and Navy came first. He predicted a shortage of 2,000 doctors in civilian practice within the year unless some plan for returning men from services could be evolved. Forty-seven per cent of Medical trainees are females or 4 F's. Dr. Paulin, the President, urged strongly for plans to educate enough men for future needs and for plans to establish courses of training for doctors returning from the services. Surgeon General Kirk spoke of the effective work of medical supplies and medical services in the invasion theater.

Admiral McIntire pledged his support to any plan which might develop to defer men for medical training and to return doctors in Service back to civilian life but both General Kirk and Admiral McIntire called attention to the fact that although 53,000 doctors or 26% were now in service some new ones would be needed. General Grant of the Medical Air Corps spoke of the plans of his service to utilize doctors for duties in which they were trained and also to train special men for specialized services and to return them to civilian practice as well equipped or better than before entering the Corps. The Secretary of the Canadian Medical Society brought greetings from our Canadian Colleagues and spoke of his hopes for a great joint meeting some day between British, Canadian, and American physicians.

The Scientific Exhibitions were remarkable as always — many excellent photographs, exhibits of war wounds, treatments, and war illnesses. New treatments for burns were prominent; rice diet for high blood pressure; care of rheumatics; and other excellent exhibits were there. The JOURNAL of the A. M. A. will bring you detailed accounts of these. The Technical Exhibit was good, featuring Penicillin. The Seventh Annual Exhibition of The American Physicians Art Association through courtesy of Mead Johnson and Company was the largest ever; over 1,000 works of art by physicians were on display. Imagine the pleasure of your delegate upon finding that one of our members, Dr. John Allen, of Portland, had been awarded a gold medal for one oil still life and honorable mention for an oil landscape. Abbott's exhibition of Naval Paintings was a splendid display.

The registration of delegates was 170 out of a possible 175. The last figure I saw for total registration was 6,653.

In review your delegate reports:

1. The meeting was well attended with definite emphasis on helping the war effort and preparing for future education and distribution of medical officers in civilian practice.

2. Resolutions were approved to improve distribution of medical services to civilian population; to prepare plans for pre-medical students; to develop plans for special courses for medical officers released from The Armed Services; to transfer the E. M. I. C. program from the Children's Bureau to the U. S. Public Health Service; to unite all services for Public Health under one department; to oppose Compulsory Health Insurance; to favor Prepaid Medical Care Plans on County and State levels; to review education of nurses and their registration; to consider the establishment of a Bureau for Economic Research in Washington.

3. State Societies were urged to appoint Committees on (a) War Participation, and (b) Medical Services and Public Relations.

4. Resolution to promote Dr. Olin West to the office of Secretary Emeritus, and to replace the Editor of the *Journal* of the A. M. A. was defeated.

5. The Scientific Exhibits featured treatments for burns and war casualties.

6. The Technical Exhibits displayed abundant information about Penicillin.

7. Dr. Roger I. Lee, of Boston, was elected President-elect.

8. Atlantic City was selected as the meeting place for 1947; the 100th Anniversary Meeting. And New York the meeting place for 1945.

CHAIRMAN BLISS: You have heard the comprehensive and interesting report of Dr. Foster. A motion is in order to accept this report.

A MEMBER: I move that the report of Dr. Thomas A. Foster as delegate to the American Medical Association be accepted and placed on file.

This motion was duly seconded and was carried.

CHAIRMAN BLISS: I shall now ask Dr. Kinghorn to report on his visit to the New Hampshire Medical Society Meeting.

DR. CHARLES W. KINGHORN, KITTERY: Mr. President and members. New Hampshire had only one day for this annual meeting of theirs. They had no conferences; they had their meetings of the House of Delegates, of course. Their Scientific Sessions in the morning and afternoon were much the same as ours, with several out-of-state speakers. In the evening, instead of the usual banquet, they adjourned to the Manchester Country Club, and put on a Buffet Supper there, with social refreshments beforehand.

CHAIRMAN BLISS: Thank you, Dr. Kinghorn. Dr. Vickers, will you please report on your visit to the Massachusetts Medical Society?

DR. MARTYN A. VICKERS, BANGOR: I ought to start this report off by first telling about the fact that I was extremely flattered by being appointed as a delegate. I thought I really represented something quite important. So I went to Boston the night before to sort of get oriented and shake the hay off myself around the Statler Hotel.

The next morning, I went down to the Registration Desk and informed them that I was the delegate from Maine, and wondered if I had any particular duties, and Dr. Dameshek introduced me to Dr. Morrison, who evidently had a great deal to do with the setting up of the meeting, and from there on I was introduced to Dr. Lee.

They had a very interesting meeting, with very interesting speakers. Dr. Graylock, Neuro-Surgeon at the Johns Hopkins, talked interestingly on the blood bank. Dr. Alvarez of the Mayo Clinic gave a talk on the gastrointestinal tract. And there were other speakers of national note.

Also Dr. Bagnall, who is the new President of the Massachusetts Medical Society, spoke. I had quite a long talk with him. He spoke about the formation of a New England Medical Council, made up of men from the various states, which they do not have now. We thought that possibly there might be delegates from each state represented, to form such a New England Medical Council, because there apparently are problems that we, as New Englanders, have in common.

I think that Boston represents pretty much the center of medical education, insofar as this particular section is concerned, and I think that maybe we would stand to gain considerably by association with the group there.

The only other thing of note was that I had a very nice time, met nice people.

The balance in the Massachusetts Medical Treasury was $248,000 and I wondered how they did so well,

but they say it is there. They are talking about buying a large place in Boston and setting it up as their headquarters.

It was a good meeting, and I enjoyed the privilege of going and representing the state, and I had a fine time.

CHAIRMAN BLISS: Thank you, Dr. Vickers.

May we hear from the Connecticut delegate, Dr. Johnson of Portland.

DR. OSCAR R. JOHNSON, PORTLAND: Mr. President and members of the House of Delegates. It was my good fortune and pleasure, through the courtesy of the Maine Medical Association, to visit the Connecticut Medical Society's Annual Meeting at Bridgeport on May 2, 3 and 4. Registration took place at 9:30. The address of welcome was given at 10:30 by the Honorable Mayor of that city. He commended the Society upon its excellent achievements in medicine and public health in the last two decades. He said he remembered well as a young man the type of medicine as practised then compared to the present day methods, and felt that the people of Bridgeport and the State of Connecticut should feel justly proud of the untiring efforts and accomplishments of medicine, with its ever increasing responsibilities due to the present war.

The scientific papers presented were given by doctors of national reputation. Each speaker, in his own field, gave a clear cut, precise, and extremely interesting paper.

Dr. Francis Blake, Dean of the Yale School of Medicine, spoke on "Penicillin in Coccal Infections;" Dr. Edward Schumann of Philadelphia concerning obstetrical experiences, who, at the end of his talk, received an applause of which no speaker need be ashamed.

Dr. Miller, Chairman of the Council of the Connecticut Society, spoke on the progress and activity of the Society, emphasizing the work done in Civilian Defense and in the Selective Service Procurement and Assignment Unit. He also felt that there was a need for greater facilities for the training of industrial physicians, since the State of Connecticut is in the forefront of industry. He also spoke about plans under way for rehabilitation programs, continued co-operation with the hospital service plans, and that he was sorry to say that the commercial carrier plan of prepaid medical service, authorized by the House of Delegates of the Society last December, would have been by now well under way were it not "that we have been so busy and because of the serious illness of a key individual in the insurance company. We hope, however, to see these contracts offered to the public before long and it is significant that one other company has approached us for approval of its contracts."

Mrs. Eben Carey of Milwaukee, President of the Women's Auxiliary of the A. M. A., spoke on the purposes of the Women's Auxiliary and urged each doctor's wife to appoint herself a committee of one to carry the facts of the Wagner-Murray-Dingell bill to groups and clubs. Sixty-five women were present and signed the charter membership roll.

Governor Raymond E. Baldwin, speaking to more than two hundred members and guests at the banquet, praised the officers and members of the medical group for their spirit of co-operation with the State government and war emergency medical service program. He also praised the Yale School of Medicine, but felt that there should be another medical school at the State University, which I learned later was not in accord with several members of the Society.

The other guest speaker scheduled to address the banquet members was the Dean of Medicine of St. Louis University, the Rev. Alphonse Schwitalla. When the announcement was made that illness prevented his presence, there was evident a note of disappointment, as I later found out he is not in favor of Federal control of medicine and therefore members were anxious to learn his sentiments.

Capt. Howard B. Sprague, U. S. N. R., Chief of Medicine in the U. S. Naval Hospital, St. Albans, N. Y., gave an illustrated address on the work of a Navy doctor in the South Pacific. He described his experiences aboard a hospital ship and with a mobile hospital unit in New Zealand, and said that "no American boy will die for want of medical attention where it is humanly possible to get it to him."

The address, without a doubt, which drew the largest attendance, was the talk by Dr. Bauer, of Hempstead, L. I., Chairman of the Council on Medical Service and Public Relations of the A. M. A. He said "that the American people are not in favor of Government control of medicine and do not want different doctors or a system other than that of private enterprise." He discussed the possibilities of voluntary prepaid service plans but felt it was up to each state to work out its own problems. He illustrated by saying that the problems of New York State cannot be compared to those of Vermont. He voiced his opposition to the Wagner-Murray-Dingell bill, "which would create a compulsory medical service plan and therefore would threaten the high standards and private enterprise for which American medicine has been noted." He felt that the relationship of patient and doctor must not be forgotten and "Bureaucracy once established is almost impossible to remove." He did feel, however, that the medical profession should provide some sort of answer to the present problem. For the present, at least, the Wagner-Murray-Dingell bill is dead but each state society should be active and on the alert concerning future bills of the same nature, and a continued effort should be made to study and re-examine the operations of other state prepaid medical service plans, bearing in mind that a more widely distributed medical service should be worked out.

CHAIRMAN BLISS: That is a very comprehensive report, and we wish to thank you, Dr. Johnson.

May we now hear from Dr. Joseph Porter, the delegate to the Rhode Island Medical Society.

DR. JOSEPH E. PORTER, PORTLAND: I was happy to receive the assignment as delegate to the Rhode Island Medical Society, and I must say that I was very cordially received by Dr. Buffum, Secretary of the Association, when I first arrived there.

The meeting opened Wednesday afternoon, May 24th, and there were two papers on that program that interested me very much. First, there was a paper given by Commander Fuller of the United States Naval Reserve. I think it was of interest because of the fact that it gives us an idea as to the restrictions that our government is placing upon these men in the service with regard to what they can say. The paper was entitled: "Results in the treatment of sixty cases of Malaria, and a Review of One Hundred Cases of Pityriasis." He came to give the paper, but he informed us that his superior would not allow him to talk about Malaria. So just what he had to say, I don't know.

The other paper on the afternoon program was "Planning for Medical Care" by Dr. James Miller of Connecticut. He reiterated many of the statements made by Governor Magrath of Rhode Island with regard to the plan already in existence there. I think one of the points to remember is that the statement that those who object to the state interfering with medical care should stop talking about states' rights, unless the individual states plan to do something for themselves.

I think the highlight of the meeting was the annual oration given by Dr. Reginald Fitz, of Boston, Wednesday evening. This oration is an annual affair,

and this year for the first time, a medal was given to the person giving that oration, in honor of Dr. Charles B. Chapin, presented by the Council of Providence. If you are not acquainted with Dr. Chapin, let me say that he was one of the pioneer public health workers in this part of the country, and to him is attributed for the first time the use of the cubicle system in the care of infectious diseases. Dr. Fitz's paper dealt, primarily, with the post-war training of internes and residents, and he emphasized the necessity for establishing a well-rounded-out program for the training of house officers, if we are to continue to keep these boys and keep them happy in the hospitals. He enumerated the various details of the plans. He also pointed out in his paper that in his job as Chairman of Procurement and Assignment for Massachusetts, that it would probably be of interest to us to know that most of the essential doctors are in the larger cities, and he could not quite understand why there are no essential doctors in small towns, even though there is only one doctor there.

The following morning, there was a series of papers given at the Rhode Island Hospital by representatives from all the hospitals in Rhode Island. Most of the papers were of a very highgrade character and very interesting.

I was unable to attend the evening meeting, and, therefore, missed the Presidential address, but all in all, the meeting was very entertaining and very interesting.

Not in the way of criticizing, but as an observation from an outsider, it seems to me that if their meetings could be organized so that they could be held in one place, they would be much easier for the outsider to attend. In other words, one had to travel to three different places in order to take in all the various meetings. [Applause]

CHAIRMAN BLISS: Thank you, Dr. Potter.

(To be continued in the October issue)

Editorial—Continued from page 179

months of age when the injections were begun. The average age was about 8 months. Three doses were given each infant. To determine the time interval factor, the infants were injected at one week intervals at St. Vincent's and at three week intervals at the Evanston Health Department Clinic.

The three week intervals between the three doses yielded a higher percentage of immunity responses than when the doses were given at one week intervals. Ninety-seven per cent of the three week interval group had negative Schick tests for diphtheria and 72 per cent had high immunity tests for whooping cough. After a stimulating dose of pertussis vaccine, the whooping cough percentage rose to 95. Reactions were transient and usually mild.

The three investigators say that "No infant so injected during the past five years . . . is known to have contracted either disease."

Book Reviews

"Central Autonomic Regulations in Health and Disease"

(With Special Reference to the Hypothalamus)

By: Heymen R. Miller, M. D., attending associate physician, Montefiore Hospital, New York City and an introduction by John F. Fulton, M. D., M. A., D. Phil. (Oxon), Sterling, professor of physiology, Yale University.

Published by Grune & Stratton, New York. Price, $5.50.

Long of the mind that the medical profession had exhibited a genuine need for a text dealing particularly with the central autonomic controls and their relations to clinical medicine, Dr. Miller after lengthy apprenticeship in neuro-anatomy and neurophysiology took pen in hand and set down his findings on a subject, the concept of which has changed greatly in the past quarter of a century.

Central Autonomic Regulations in Health and Disease was created by Dr. Miller primarily from the point of view and out of the need of the clinician. It affords, among other features, an intelligent appraisal of the autonomic functions and purports to prove that many patterns of clinical disease are partially or wholly expressions of autonomic activity.

In an introductory comment, Dr. Fulton writes, "The somewhat unorthodox presentation of physiologic and clinical matter prior to anatomic treatment is as challenging as it is original."

"Metastases"

By: Malford W. Thewlis, M. D., attending specialist, general medicine, U. S. Public Health Hospitals, New York City; attending physician, South County Hospital, Wakefield, R. I., special consultant, Rhode Island Department of Public Health.

With 13 illustrations and a foreword by Hubert A. Royster, A. B., M. D., F. A. C. S.

Published by Charlotte Medical Press, Charlotte, N. C. Price, $5.00.

Prepared in a tabulated arrangement with separate headings given an alphabetical list of the organs and structures in which disease may originate, this edition on the subject of "Metastases" might well take its place among the frequently used books on any medical man's library shelf.

Dr. Thewlis purposely arranged the book in its tabulated form in order that the medical man could, at a glance, note the secondary site as it is associated with the primary lesion. The author warns, however, that metastasis does not follow a definite course, yet he suggests the most likely routes from a given region to a distant part in the involvement of many infections.

The publication is the result of many years of extensive research and by far a majority of the medical and surgical metastases cited are based on actual case history.

In a preface, Dr. Thewlis notes the observation that "if (this book) helps some to trace quickly embolism, infarction, infection and metastasis of tumors, it will have served its purpose."

Presidential Address—Continued from page 174

One cannot review the past year without realizing the ever-increasing value of the Associated Hospital Service both to the hospitals and to its subscribers. Some 80,000 Maine citizens are already carrying this prepayment hospital insurance. The more our hospitals can influence the further expansion of the Blue Cross, the greater good they will be doing our people in enabling them to avoid the disaster of unprepared-for, catastrophic illness.

I cannot refrain from saying a few words regarding the hospital's responsibility for the maintaining of high standards of professional Service. Too often this is side-stepped, or if the service is not as it should be, considered a condition impossible to do anything about. This is especially so in these times when the War and the shortage of physicians serve as too-ready excuses. This responsibility for the patient, to afford him every safeguard and the best medical care, cannot be shrugged off. Once admitted, a patient is the hospital's patient and the responsibility for his well-being devolves upon the hospital. In like manner the responsibility for good records and regular staff meetings rests upon the hospital and its Trustees. No let-down should be countenanced.

Sometime ago, our Secretary, called my attention to Francis Meehan's "Living Upstairs." Meehan begins his book as follows:

"Two stories has the House of Life. If a man's home is his castle, the citadel is upstairs. Downstairs we greet the grocery boy, argue with the plumber, hire and fire the cook, dodge subscribing for magazines to help a manifestly unacademic youth through college. Upstairs we entertain friends who inspire and encourage us, people we know and love." And so he goes on, to the effect that the inspirational, the idealistic, the higher aims of Life are found in this upstairs region.

Our Hospital House likewise has two stories. During the past few years we have been so concerned about maintaining the necessities, about grocery deliveries, getting coal for our furnace, keeping our help and trying to meet our bills, that we have had to spend too much time on the lower floor. Haven't we perhaps neglected the housekeeping in the upstairs rooms? Don't they need a little refurnishing, or at least the windows opened to let in a breath of fresh air? For after all the idealism upon which our hospital work is based is engendered in the upstairs rooms. Would it not be good for us all to go upstairs a little more often? Wouldn't our prospective be lengthened and our value to Humanity increased? Let me urge that we begin to reacquaint ourselves with the upstairs of our Hospital House.

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Meningococcic Infections
*(With a Report of 35 Cases)**

Rudolph Haas, M. D., Lewiston, Maine

The number of meningococcic infections has shown a considerable increase during the past two years. Wherever large groups of people have been in close contact, as in army camps and shipyard areas, local epidemics have developed frequently. With this has come an increase in certain forms of meningococcic infections which have been less readily recognized until recently. Therefore a short review of these aspects of meningococcic infections seems justified.

The infection as such is spread by carriers whose naso-pharynx has become infested with meningococci without symptoms or under the picture of a sore throat.[2] The rate of carriers can reach as much as 57% during the height of an epidemic.[6] According to a report by Cheever[6] it was possible to clear throats from meningococci in nearly 100% of his cases by giving eight grams of sulfadiazine within 72 hours. Direct transmission of meningitis from patients appears to be an extremely rare occurrence.

It is now generally accepted that meningococcic infections occur in one or all of three stages which follow each other at varying speed. The first stage is that of nasopharyngitis; the second stage is the one of meningococcemia, either acute, fulminating, or chronic; the third is that of metastases to meningae or to joints.[2, 9]

A. Meningococcemia. The first stage of a meningococcic infection makes its appearance in the form of a non-characteristic upper respiratory infection. After a certain interval, from several days to two weeks, meningococcemia develops with sudden onset of chills and fever accompanied by headache, nausea and vomiting, general malaise and joint pains or myalgia in arms and legs. A skin rash is the most constant symptom and consists most frequently of petechiae, less often it appears in form of pinkish, macular lesions. Occasionally the rash is very scant and has to be looked for carefully since it might be found only over the chest and abdomen or even only over the plantar surface of the feet.[4] The temperature curve often shows a characteristic course either of quotidien, tertian or quartan type.[3]

The laboratory data in these cases reveal marked increase of leukocytes from 12,000 to 30,000 per cmm. Normal white counts are the

* From the medical service of the Central Maine General Hospital, Lewiston, Maine.

exception. In the largest series reported, the blood cultures were positive in 56% of the cases,[1] while in another series 87% positive blood cultures were obtained.[3]

A number of meningococcic infections do not progress beyond the stage of meningococcemia which can persist for a varying period of time. Mild infections may clear up without treatment, severe ones if untreated progress more or less rapidly to the next stages. The bacteremia can last from several hours to several weeks, the longest period reported being eight months.[3] Recently, many patients have been diagnosed and treated in the stage of meningococcemia; such was the case in 32 out of 112 meningococcic infections seen at Fort Bragg,[1] in 13 cases out of 68 at Camp Edwards,[2] and in 8 cases out of 51 at the Boston City Hospital.[3]

The treatment of meningococcemia has been very successful; in the series above mentioned, 4 to 5 gms. of sulfadiazine were given initially, followed by 1 gm. every four hours. The fever subsided rapidly, often within 24 hours, and all other signs cleared up without residual and in none of these cases did meningitis develop.

Meningococcemia complicated by adrenal hemorrhages forms the fulminating type which usually runs a rapidly fatal course, often within 12 to 24 hours; this clinical picture represents the Waterhouse-Friderichsen Syndrome. This syndrome has been quite well known in small children, but recently has occurred more and more frequently in adults as well.[8] It is characterized by sudden onset of illness, purpura, early circulatory collapse and coma without signs of meningitis. The blood pressure is ex-

TABULATION OF CASES

No.	Age	Temperature on Entry	Wbc. on Admission	Spinal Fluid Cell Count	Meningococci in Sp. Fl.	Duration of Drug Medic.	Serum	Complications	Results
1	38 yrs.	103.4	4.700	—	bloodcult. +	—	—	—	deceased
2	63 yrs.	104.4	4.500	2	bloodcult. +	—	—	—	deceased
3	23 yrs.	101.0	27.000	11.700	—	8 days	—	—	deceased
4	8 yrs.	104.0	12.600	1.220	+	7 days	+	arthritis deafness and	recovered
5	18 yrs.	103.6	10.000	20.000	+	6 days	+	drug rash	recovered
6	25 yrs.	98.0	9.250	15.000	++	5 days	+	drug rash	recovered
7	40 yrs.	101.0	21.700	12.200	++	10 days	—	phlebitis	recovered
8	8 yrs.	103.8	32.000	22.000	+	15 days	—	—	recovered
9	48 yrs.	102.6	32.700	37.000	+	1 day	—	—	deceased
10	26 yrs.	100.0	16.000	8.300	—	8 days	—	—	recovered
11	58 yrs.	100.0	14.600	13.200	culture +	10 days	—	—	recovered
12	30 yrs.	102.0	22.000	37.600	++	9 days	—	—	recovered
13	5 yrs.	102.0	11.800	6.600	+	5 days	—	—	recovered
14	39 yrs.	100.8	6.000	8.700	+	6 days	—	—	recovered
15	33 yrs.	98.0	25.700	24.300	++	12 days	—	arthritis	recovered
16	46 yrs.	102.6	15.100	26.000	+	9 days	—	—	recovered
17	9 yrs.	100.0	34.700	11.600	—	6 days	—	—	recovered
18	50 yrs.	100.0	30.900	20.600	++	8 days	—	—	recovered
19	4 yrs.	102.6	24.200	125	+	1 day	—	—	deceased
20	11 yrs.	—	—	4.600	++	—	—	—	deceased
21	46 yrs.	100.0	18.500	4.200	+	11 days	—	drug rash deafness	recovered
22	4 yrs.	101.6	21.000	5.400	+	9 days	—	—	recovered
23	53 yrs.	99.8	10.250	2.050	—	6 days	—	drug rash	recovered
24	3 yrs.	101.0	16.000	3.000	+	8 days	—	—	recovered
25	6 yrs.	103.8	31.400	8.800	—	8 days	—	drug rash drug fever	recovered
26	41 yrs.	100.8	11.800	6.380	++	2 days	—	—	deceased
27	39 yrs.	98.0	17.500	3.100	+	17 days	—	arthritis	recovered
28	2 yrs.	102.0	18.500	12.200	+	9 days	—	—	recovered
29	3 mos.	101.8	12.300	3.000	++	7 days	—	pneumonia	recovered
30	12 yrs.	103.2	15.200	8.300	+	5 days	—	arthritis	recovered
31	7 yrs.	103.0	14.400	4.280	—	5 days	—	—	recovered
32	3 yrs.	104.0	12.850	4.550	—	7 days	—	—	recovered
33	2 yrs.	104.0	19.800	927	++	11 days	—	arthritis	recovered
34	64 yrs.	99.0	21.900	40.800	—	5 days	—	—	recovered
35	7 yrs.	98.0	19.900	1.260	+	7 days	—	—	recovered

tremely low, marked leukocytosis or leukopenia is found. The spinal fluid is negative while the blood cultures or smears from the skin lesions reveal meningococci.

During the years 1942 and 1943, two cases of fulminating meningococcemia out of 35 meningococcic infections were observed on the wards of the Central Maine General Hospital. Both patients died within 28 hours after onset of symptoms and within four and nine hours respectively after admission; one of them had complained of a sore throat in the evening and was found unconscious the following morning.

The treatment in these cases of fulminating meningococcemia should consist of administration of epinephrine, as well as adrenal cortical extract in doses of 10 c.c. every 4 to 6 hours intravenously or intramuscularly, and desoxycorticosterone 5 mg. intramuscularly every two hours until the blood pressure exceeds 100 mm. Hg. An initial dose of 5 gms. of Sodium Sulfadiazine intravenously followed by 2.5 grams every 6 hours should be given and intravenous glucose-saline infusions of 3,000 to 4,000 c.c. daily are needed.[8]

Recovery in these patients is extremely rare and has been reported only in seven instances out of a total of 146 reported cases, but early institution of vigorous treatment improves the prognosis.

B. Meningitis. Meningococcemia, if untreated, may at any time turn into meningitis; it does so as a rule within a few hours to one to two days. The average interval between the chill and petechiae (as the onset of the blood stream invasion) and the first symptoms of meningitis lasts about 30 hours, others run from 3 to 14 days.[1] The skin rash may or may not subside before the onset of the meningitis; in one of our cases, petechiae had appeared 24 hours prior to entry and had subsided before admission (No. 19). The most constant symptoms of meningitis are the headache, the stiffness of the neck, nausea and vomiting. Skin rash, joint pains and stupor is found frequently; in severe cases confusion and delirium are seen. The latter may be the first spectacular symptoms due to an extremely short initial period.

During the years 1942 and 1943, a total of 33 cases of meningitis were treated at the Central Maine General Hospital. The age of the patients ranged from 3 months to 64 years, with a total of 17 children. The initial temperatures varied from 98° F. to 104° with 14 patients showing a fever of 102° and above.

The blood counts ranged from 6,000 leukocytes per cmm. to 34,700 with an average of 19,300 leukocytes per cmm. Only two counts below 10,000 white cells were found.

The spinal fluid cell counts varied from 125 cells per cmm. to 40,800 cells per cmm. with an average of 11,800; sugar was absent in all initial spinal fluid specimens; Meningococci were found in 24 out of 33 cases or in 72.8%. In one additional case of a negative direct smear, meningococci were found on culturing the spinal fluid.

Since blood cultures are negative in as many as 50% of the cases and are difficult to obtain because of technical intricacies, direct smears from the skin lesions have been advocated lately as an additional method to determine the etiology and have made possible the finding of meningococci in 80% of a small series.[7]

The treatment of meningitis has become simplified since the introduction of the sulfa drugs; the mortality rate has dropped sharply. Before the era of serum treatment it varied from 20-90%; with serum therapy it dropped to 20-40%. Under sulfanilamide, the mortality rate came down to 14% and in recent epidemics it decreased further to 6-8% or better. Combination of serum with sulfa drugs never gave quite as favorable a result as treatment with sulfa drugs alone.[5]

Sulfadiazine, from all indications, is the drug of choice at the present time. Some observers have given the drug by mouth or by stomach tube if the patient was unable to swallow. By now, almost everyone agrees that it is most beneficial to give the sulfadiazine intravenously for the initial dose, or even for the first 24 hours or until definite improvement becomes noticeable, and then to continue by oral route. The optimal blood level has not yet been established. In one series where an initial dose of 0.1 gm. of sodium sulfadiazine per kilogram of body weight was given, followed by one-half of this dose every eight hours thereafter, the results were less favorable than in a series where one-half of the above-mentioned dose was given. The blood levels in the first group

reached 15 mg. % while those of the second group ranged in the neighborhood of 8 mg. %.[1] In our series of 27 cases during 1943, we used the following scheme: an initial dose of 5 gm. of sodium sulfadiazine was given intravenously followed by 2.5 gm. every 6 hours until the patient was able to take medications by mouth. In children, the dose was adjusted according to age and weight. The blood levels obtained reached 12-24 mg. %. The spinal fluid sulfadiazine levels amounted to ⅔ of the blood levels. The drug was continued for an average of 8.2 days. Lumbar puncture was not repeated as a rule except for instances of severe symptoms of increased intracranial pressure. Intravenous glucose-saline infusions were given to maintain an intake of 2,000-3,000 c.c. daily.

The results of the treatment in our series showed a higher mortality than the average. Of a total of 33 cases, 4 died, one of them 2 hours after admission; omitting this case, a total mortality of 9.4% results. The most frequent complication was the appearance of a drug rash, which occurred in 5 cases; arthritis developed in 5 cases, the earliest on the 4th day, the latest on the 10th day. It is difficult to determine definitely whether these arthritic symptoms occur as metastases of the meningococcemia or are due to the sulfa drug. Marangoni and D'Agati[5] feel that the existence of a sulfadiazine arthritis has been established. It characteristically occurs during a period of improvement and is not accompanied by leukocytosis. All of our cases cleared up and no permanent joint damage was observed. Two cases showed residual deafness which has persisted. No other residual damage occurred in any case. No renal complications occurred except for occasional microscopic hematuria particularly in small children.

C. Meningococcic Arthritis. Meningococcemia can cause metastases to the joints and does so often under a picture similar to rheumatic fever. After the prodromal upper respiratory infection the patient begins to have joint pains, with or without swelling and reddening, of one or more joints, particularly the knees or elbows. A petechial or macular skin rash is found frequently and its presence will establish the diagnosis. The rash may be very scanty and has to be looked for. Muscle aches and pains in the arms and legs are present in many cases and are of differential diagnostic importance.[4] The high leukocyte count is characteristic as well. One of our cases (No. 5) gives an illustration of this type of meningococcic infection where first metastases to joints occurred and later with a second shower metastasis to meningae set it. An 18-year-old student nurse was admitted because of marked pain in her ankles and feet; she was examined by the orthopedic service, and was treated for rheumatic arthritis for 24 hours. The right foot appeared swollen, reddened and was tender to touch. She had a temperature of 103.4° and a white blood count of 10,000 per cmm. The pain spread to both shoulders and all fingers and the patient had muscle aches in all extremities. Twenty-eight hours after onset of joint pains a chill occurred followed by the appearance of petechiae. Stiffness of the neck and vomiting developed and patient later on became drowsy. A lumbar puncture then revealed cloudy fluid showing gram negative intracellular diplococci. The patient recovered after institution of sulfa drug medication.

The treatment of meningococcic arthritis in general is sulfadiazine medication in doses similar to those used in the treatment of meningitis and the response is rapid.[4] Chronic meningococcemia can cause recurrent attacks of joint pains and swelling and fever and scant skin rashes; this form too will respond to sulfadiazine.[4]

Summary

A review of the different forms of meningococcic infections is given. The common occurrence of meningococcemia without meningitis is shown in recent reports in the literature. Diagnosis and treatment in this stage is possible and to be attempted; two cases of fulminating meningococcemia are described. Meningitis is to be regarded as metastatic inflammation in meningococcemia. Treatment of choice is sulfadiazine; results of therapy in 33 cases of meningitis are described; a mortality of 9.4% is found. Meningococcic arthritis as another metastatic manifestation of meningococcemia is mentioned.

Continued on page 198

Multiple Carcinoid Tumors of the Ileum

REPORT OF CASE

Albert P. Royal, Jr., M. D., Rumford, Maine

Carcinoid Tumors are generally accepted as primary tumors of the small bowel, including the appendix. They are known to be fairly common in the appendix, usually discovered by accident during routine examination of appendices removed at Surgery. They seldom give rise to symptoms in the appendix. These tumors are less often found in the small bowel, often multiple, but in a higher percentage of cases produce symptoms, the most common of which are those of obstruction.

The tumors are called carcinoid because they resemble carcinoma but originally were believed to be benign in nature. It is now generally accepted that they arise from the Argentaffine cells of the crypts of Lieberkühn which cells are found throughout the gastro-intestinal tract but are most abundant in the appendix and terminal ileum. Further investigation of these tumors has revealed the fact that they do mestasticize both to the regional lymph nodes and liver, and infiltrate surrounding tissues although this latter characteristic seems to be mainly a function of increase in size.

A study of previously reported cases of carcinoid of the ileum, either single or multiple, reveals that many cases presented no symptoms. The most common symptoms were those of obstruction, either acute or chronic, and miscellaneous complaints as due to intussusception or tumor mass.

The case presented below is unusual in that while the patient had had post-prandial distress, sometimes amounting to moderate pain, and constipation, his admission to the hospital was brought about by an acute attack of severe generalized abdominal pain, suggesting some acute surgical condition other than mechanical obstruction.

The patient, E. T., age thirty-nine, was admitted to the Rumford Community Hospital complaining of abdominal pain of eighteen hours' duration.

For the past five years he has been extremely constipated, never having a bowel movement without laxative. During this time, he has had some mild abdominal discomfort at times, but not related to food. He has eaten all kinds of foods without noticing distress from any save possibly baked beans.

Two weeks ago, he had an attack of obstipation lasting about three days, accompanied by mild epigastric pain, nausea and vomiting. He finally got his bowels to move by means of laxatives and enemas and then he felt better. Since then until the onset of his acute symptoms he has had mild colicky pain without much flatus and not related to meals. During this time also his appetite has been poor and he has had to take more laxative than usual.

About eighteen hours ago, he was awakened with a severe pain in the mid-back which seemed to radiate directly through to the umbilicus. This was steady, knifelike in character, did not radiate otherwise, and was soon accompanied by vomiting. After about six hours the pain seemed to shift downward into both lower quadrants with equal intensity. The vomiting persisted. He took several of his laxative tablets and applied heat to the abdomen, all without relief. About five p. m., he took a large dose of castor oil which seemed to relieve him for a few minutes but did not produce a bowel movement. Soon after this the pain became much more severe, remained steady in character and was generalized over the entire abdomen, worse in both lower quadrants, and the pain in the back persisted.

The only other significant factor in the patient's history was right sacro-iliac pain with sciatic distribution, which had been more or less constant for three years, temporarily relieved by osteopathic treatments.

Physical examination revealed a well developed, fairly well nourished adult male lying in bed showing no appreciable shock but acute distress. Temperature 98.2. Pulse, 74. Respirations, 20. Examination essentially negative except for abdomen which was board-like throughout with marked tenderness, more pro-

nounced in both lower quadrants and most marked in the right lower quadrant. There was no rebound or contra-lateral tenderness. No organs or masses could be felt, and there was no appreciable distention.

Admission laboratory work revealed a white blood count of 21,300 with 68% neutrophils and 21% band forms with 15% lymphocytes and 2% monocytes. Urinalysis revealed only 1 plus acetone as an abnormal finding. Chest plate in upright position revealed no air under the diaphragm.

The patient was taken immediately to the operating room with a working diagnosis of acute appendix or perforated peptic ulcer. Under G. O. E. anaesthesia a right rectus muscle splitting incision was made and the abdomen opened. No free fluid escaped. The bowel was not distended. Appendix, stomach, duodenum, gall bladder all found to be normal. Terminal ileum was adherent and freed with difficulty. Examination of small bowel then revealed what appeared to be two small ulcers located at twenty-four inches and thirty inches from the caecum, the first, very small, the second, about the size of a quarter, thickened, indurated, white, feeling like either malignancy or chronic ulcer. This lesion was excised and the abdomen closed with a diagnosis of either small bowel malignancy or possibly ulceration of a gastric mucosal implant, pending pathological report.

Immediate post-operative convalescence was good. On the fifth post-operative day patient developed signs of mechanical obstruction and the Levine tube which had been used to decompress the stomach was removed and the Miller-Abbott tube inserted into the duodenum under the fluoroscope. Within six hours the tube had traveled to the six-foot mark and his signs rapidly subsided.

The pathological report from Dr. H. E. MacMahon of Tufts Medical School was Carcinoid of the Ileum with mucosal ulceration and extension to the serosal surface.

Twelve days later, the patient was again submitted to surgery, with the Miller-Abbott tube in place and fourteen inches of ileum resected to include the second lesion and adjacent mesentery. No lymph nodes or nodules in the liver were found.

The patient made an uneventful recovery and was discharged on the fifteenth post-operative day, twenty-seven days after admission, symptom-free.

The patient was seen frequently during the next three months. He felt in excellent health, appetite good. Bowels regular without laxative. After three months he gradually increased his diet from low residue to an unrestricted diet and had one attack of intermittent abdominal cramps lasting a few hours, following a dietary indiscretion.

He remains in good health one year from date except for backache with sciatic distribution.

Interesting observations on this case are as follows:

First, the ease of abdominal surgery when the bowel is decompressed with the Miller-Abbott tube.

Second, the apparent cure of troublesome constipation by the removal of two carcinoid tumors of the ileum.

Third, the acute abdominal symptoms which could be accounted for by no other pathology except the carcinoid tumors. No obstruction was present and no definite perforation of the ulcer was found but there certainly must have been irritation of the serosal surfaces to have caused the severity of symptoms and the leukocyte response which were found on admission. The symptoms were definitely relieved by the removal of the tumors and there has been no evidence of recurrence.

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Editorial

Symposium Shows the Value of Penicillin for Syphilis

Penicillin appears to be the most effective drug yet found for the treatment of syphilis in both its early and late stages but mass treatment with the new substance should be delayed until the optimal treatment schedule and other factors have been determined, according to a symposium published in *The Journal of the American Medical Association* for September 9.

The symposium consists of three papers, together with discussions; two of them being reports on studies of the treatment of early syphilis with penicillin, and one on the action of the drug in late syphilis. All three of them emphasize the need of long trials of treatment, with varying schedules, and carefully controlled follow-up systems involving large numbers of patients, because of the chronicity of the disease, its long periods of latency and its tendency to recur.

In the treatment of early syphilis with penicillin, it appears that very early infections respond in the most favorable manner and that there may be a certain percentage of patients who fail to experience the same curative response which may be demonstrable in the majority of patients, J. F. Mahoney, M. D.; R. C. Arnold, M. D.; Burton L. Sterner, M. D.; Ad Harris and M. R. Zwally, M. A.; U. S. Public Health Service, Staten Island, New York, report. Their findings are based on post-treatment observation in excess of 300 days for a group of 4 patients who were the basis for an earlier preliminary report of a curtailed period of observation. They also report their early findings on an additional group of 100 patients. The treatment consisted of injections into a muscle of 20,000 units of penicillin administered at three-hour intervals, night and day, for sixty injections, the total amount of penicillin used being 1,200,000 units. No other antisyphilitic medication was used.

From the findings of their studies thus far, the investigators also say:

"A majority of patients with early syphilis appear to respond to treatment in a satisfactory manner, as judged by the clinical course and the trend of the serologic reactions. A small group in the present series (7 definitely and 2 probably) appear to have derived a minimum of permanent benefit and must be considered as treatment failures.

"In sulfonamide therapy of gonorrhea, failures of this type are classed as sulfonamide resistant and much has been written in regard to the resistance of strains of Neisseria gonorrhœae [the organism causing gonorrhea]. While accepting as possible that strain characteristics may play a role in determining the effectiveness of a therapy, it is felt that certain host factors are largely responsible for determining whether or not an agent, as penicillin, will be effective in infections which are amenable, as a rule, to treatment. It is felt that one of the most important problems in chemotherapy is a delineation of this essential factor and the development of means through which it may be favorably influenced. . . .

"The making available of a pure or reasonably pure penicillin might effect a distinct change in the treatment picture both as to results produced and as to the duration of treatment, dosage and the interval between injections. . . ."

Important among the findings in another report in the symposium concerning the treatment of early syphilis with penicillin is that the drug has a profound immediate effect in the disappearance of surface organisms of the disease from the syphilitic wound or chancre, the healing of the chancre, and a trend toward a reversal of the positive serologic tests.

This report is presented by Joseph Earle Moore, M. D., Baltimore; Dr. Mahoney; Comdr. Walter Schwartz (MC), U. S. N.; Lieut. Col. Thomas Sternberg, M. C., A. U. S.; and W. Barry Wood, M. D., St. Louis. It is a preliminary report on 1,418 cases studied in twenty-three clinics or research centers under the general auspices of the Committee on Medical Research of the Office of Scientific Re-

search and Development, and under the specific direction of the Subcommittee on Venereal Diseases, National Research Council.

The authors also say that "The lowest incidence of relapse—and the most favorable serologic response—was in small groups of patients treated with 60,000 and 300,000 units respectively of penicillin plus a known subcurative dose of mapharsen.

"Penicillin has a favorable effect in early asymptomatic neurosyphilis [syphilis of the central nervous system with no perceptible symptoms], acute syphilitic meningitis [syphilitic inflammation of the membranes which envelop the brain and spinal cord], early syphilis treatment resistant to arsenic and bismuth and infantile congenital [infection in the womb] syphilis. . . .

"The optimum time-dose relationship of penicillin in early syphilis is not yet established. . . ."

The third paper in the symposium is a preliminary report on the action of penicillin on late syphilis, including neurosyphilis, benign late syphilis and late congenital syphilis. The report is presented by John H. Stokes, M. D., Philadelphia; Col. Sternberg; Comdr. Schwartz; Dr. Mahoney; Dr. Moore; and Dr. Wood. It is based on studies made at eight clinics under the general auspices of the Committee on Medical Research of the Office of Scientific Research and Development. The information reported is based on material collected from 182 cases observed for periods ranging from eight to 214 days after the institution of treatment.

Following are some of the results reported:

In 30 cases of simple demented paresis on which data were adequate for classification, 80 per cent improved to some degree; nearly half improved 50 per cent or more, including 8 who improved 75 per cent and 1 restored to normal. Two of 10 cases of deteriorated paresis improved 75 per cent; 1, 50 per cent; 7, no change. In tabes dorsalis or locomotor ataxia, one-fifth of 14 cases improved 50 per cent or more. In meningovascular neurosyphilis, in which the substance of the brain and spinal cord as well as the membranes that envelop them are involved, 40 per cent of the patients improved 50 to 75 per cent.

It was found that previous treatment for syphilis by older methods in neurosyphilis, including fever therapy, does not appear to prepare patients for superior results with penicillin.

Infantile Paralysis

Peak of 1944 Epidemic Passed

The peak of the 1944 epidemic of infantile paralysis for the nation as a whole apparently has been passed, and the incidence of the disease is now tapering off, according to the latest reports received by The National Foundation for Infantile Paralysis, Basil O'Connor, Foundation president, declared Monday, September 25th.

The heaviest incidence of cases for the nation occurred in the week of September 2nd when 1,683 cases were reported to the U. S. Public Health Service. The week of September 9th showed a drop to 1,487, and reports since then from epidemic states indicate the decline is continuing.

The total for the year up to September 9th was 10,959 cases, or more cases for the comparable period than at any time since America's worst epidemic year in 1916.

This year's total for the first 36 weeks is 2,030 cases higher than for the same period in 1931, which to date is the second highest epidemic year.

In combatting the epidemic, the National Foundation has sent out seven doctors, 50 physical therapists and more than seven tons of wool as well as emergency financial relief. The American Red Cross has recruited approximately 700 nurses to supplement local facilities in epidemic areas. All 26 of the respirators owned by the National Foundation are still in active use, Mr. O'Connor reported.

COUNTY SOCIETIES

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County News and Notes

Oxford

The annual meeting of the Oxford County Medical Society was held at Bethel Inn, Bethel, Maine, September 20, 1944.

The meeting was called to order by the President, P. B. Aucoin, M. D.

At the business session, Abraham L. Rauchwerger, M. D., of West Paris, was elected to membership. The following officers were elected for the ensuing year:

President, H. Louella Noyes, M. D., Rumford.

Vice President, H. W. Stanwood, M. D., Rumford.

Secretary-Treasurer, J. S. Sturtevant, M. D., Dixfield.

Councilors: Drs. J. A. MacDougall, R. E. Hubbard, and Lester Adams.

Delegates to the 1945 annual session of the Maine Medical Association: G. G. Defoe, M. D., Dixfield; and R. R. Tibbetts, M. D., Bethel. Alternates: A. P. Royal, M. D., Rumford; and D. M. Stewart, M. D., South Paris.

The annual banquet was at 6.30 P. M., after which the speaker, Ralf S. Martin, M. D., of Portland, gave a very interesting and instructive talk on "Acute Endocarditis."

J. S. Sturtevant, M. D.,
Secretary.

Somerset

The following officers were elected for the ensuing year at the annual meeting of the Somerset County Medical Society held at the Carrabasset Inn, North Anson, Maine, Thursday, September 21, 1944.

President, Harvey F. Doe, M. D., Fairfield.

Vice President, Eugene L. Hutchins, M. D., North New Portland.

Secretary-Treasurer, Maurice E. Lord, M. D., Skowhegan.

Board of Censors: Drs. H. E. Marston, E. D. Humphreys, and W. S. Milliken.

Delegate to the 1945 annual meeting of the Maine Medical Association: George E. Young, M. D., Skowhegan. Alternate, M. S. Philbrick, M. D., Skowhegan.

The speaker of the evening was Frederick R. Carter, M. D., of Portland. Subject, "War Neurosis."

Maurice E. Lord, M. D.,
Secretary.

New Member

Oxford

Abraham L. Rauchwerger, M. D., West Paris, Maine.

Necrology

Henry Marshall Swift, M. D., 1872-1944

Henry Marshall Swift, M. D., 72, of Cape Elizabeth, Maine, died Friday, August 18, 1944, in his home after a two-weeks' illness.

Born in Marlboro, Massachusetts, February 16, 1872, he was the son of William Joseph and Hannah Stearns Swift. He attended Noble School at Dedham, Massachusetts, received an AB Degree at Harvard University, in three years, and was graduated from Harvard Medical School, cum laude, in 1900. He interned at Worcester City Hospital, Worcester, Massachusetts, and later was made assistant physician at the Danvers State Hospital, Danvers, Massachusetts.

Doctor Swift studied abroad and practiced in Boston and was on the staff of Tufts Medical School until 1912, when he moved to this city. He was a professor of neurology in the Maine Medical School, Bowdoin, and consulting neurologist for the Maine General Hospital. He retired a year ago.

He served overseas with the Army Medical Corps in World War One.

Doctor Swift was a member of the Cumberland County Medical Association, the Maine Medical Association, the American Medical Association, and the Portland Medical Club. He was a past president of the Portland Medical Club, and the Cumberland County Association.

In 1928, he married Miss Helen Marie Cobb, of Portland, who died in 1942.

Notices

Maine State Conference of Social Welfare

The thirty-fifth Annual Conference of Social Welfare will be held in Bangor, Maine, Wednesday and Thursday, November 8th and 9th, 1944.

Speakers will include Dr. C. L. Williams of the U. S. Public Health Service; Dr. Frederick C. Thorne, Director, Brandon State School, Vermont; and Lt. Col. Wilfred Bloomberg, Neuro-Psychiatric Consultant to the First Service Command, U. S. Army. Topics to be discussed by these speakers will be *Public Health Goals in Maine; A State-Wide Mental Hygiene Program,* and *The Health and Psychiatric Problems of the Returning Veteran.*

A registration fee of $1.00 covers all conference meetings, provides voting membership, and entitles the registrant to four issues yearly of the *Maine Welfare News.*

Any member interested in attending these conferences can secure a program by writing to the President, Mrs. Elizabeth F. Thorndike, Bar Harbor, Maine.

Former Maine Physician on U. S. Public Health Service Program

Ruth Boring Thomas, M. D., formerly of Dover-Foxcroft, Maine, now in charge of the Rapid Treatment Center at Bellevue Hospital, New York City, is listed among the specialists giving lectures and demonstrations on the management and control of venereal diseases at the eighth post-graduate course in the clinical management and public health control of venereal diseases being conducted at the U. S. Public Health Service Medical Center, Hot Springs National Park, Arkansas, October 19 to November 8, 1944.

New England Cancer Association to Meet at Maine General Hospital

The Maine General Hospital will act as host to the New England Cancer Association on October 13, 1944. The scientific meeting will begin at 12.00 noon. All interested physicians are invited to attend.

Meningococcic Infections—Continued from page 192

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Proceedings

NINETY-FIRST ANNUAL SESSION

Maine Medical Association

ROCKLAND, MAINE

JUNE 25, 26, 27, 1944

First Meeting, House of Delegates Continued from the September Issue of the Journal, Page 186

CHAIRMAN BLISS: We shall now have reports of committees, not published in the June issue of the JOURNAL.

We shall now have the report of the Committee on Maternal and Child Welfare, by Dr. Albert W. Fellows of Bangor.

DR. ALBERT W. FELLOWS, Bangor: Because of the burden of practice carried by most physicians, your committee has not been able to accomplish all it desired. We have met twice with the Maternal and Child Health Section of the Bureau of Public Health for discussion of problems connected with the E. M. I. C. program. Many of these have been solved in a manner which we hope has been satisfactory to the Society. The Committee feels that it can recommend the Program.

Articles have appeared in THE JOURNAL. We regret that the number has fallen short of twelve, but hope that the ones that did appear have been helpful. It has been our policy to have them wholly practical in nature.

Thus far no County Society, as far as we know, has devoted a meeting to the problems of maternal and infant care. This is disappointing because there is much to be done. The maternal and infant mortality in this State is too high. If all of us work together we can lower it.

CHAIRMAN BLISS: Thank you for the report. I also wish to say that we are not unmindful of the good work done by your Committee in the past year and the reports sent to the JOURNAL are only an indication of what you have done. We are very grateful to you.

The next report is that of the Committee to Survey Hospital and Medical Care, by Dr. S. Judd Beach of Portland.

DR. S. JUDD BEACH, Portland. I am presenting what I hope is the final report of this Committee.

This committee was appointed in 1940 by the President, Dr. Thomas A. Foster, with approval of the Council. The underlying motive was probably a hope to provide an antidote for Federal interference with medical practise, by ascertaining whether Maine suffered materially from lack of medical care and suggesting suitable remedies if needed.

The committee comprised a representative from each district, and from the Department of Health and Welfare. It has been stricken by the death of two members, Dr. J. C. Oram and Dr. E. M. Cook.

At the organization meeting in Augusta, February 16, 1940, the State Department agreed to report any instances of lack of care and hospital opportunities, uncovered by their staff throughout the state. Although useful information was obtained from them, this phase was dropped, because the drain on the medical profession due to our entry into the war distorted the situation and also made it impossible to benefit.

Study had also been underway of the various plans throughout the country for extension of medical service. This was continued. The only sort of arrangement not in our opinion too elaborate and expensive for Maine, was that which had just been adopted by Massachusetts. A sub-committee, Dr. Foster and Dr. Beach, interviewed Dr. J. C. McCann, Chairman of the Massachusetts Committee, with the result that our committee advised that the House of Delegates invite Dr. McCann to explain the Massachusetts Plan. Dr. McCann is a native of Bangor and was quite willing to appear. This recommendation was adopted but never carried out.

Last fall, however, the Council, at a meeting, heard Dr. McCann, and appointed a committee to present a similar plan for the consideration of the County Societies. Whether this plan would have received a more favorable hearing if the larger audience of the House of Delegates had heard Dr. McCann, or whether a preliminary presentation to the societies of the background of the prepayment plans now being rapidly adopted throughout the nation might have changed the result is a matter of conjecture. In view of the outcome there seems to be no need for further activity on the part of this committee.

Probably we should mention one aspect that is already receiving attention nationally. Due to the accelerated training program it is estimated that the number of physicians seeking places after the war will be appreciably higher than normal. The committee respectfully suggests that arrangements be undertaken for the participation of the profession in placement and distribution of physicians after demobilization. This problem is more urgent in this state owing to the high proportion of patriotic physicians entering service, whose places, partly perhaps owing to restrictive regulations, have not been filled. To be considered are the many practises and occasional hospitals that have fallen to the cults.

The committee respectfully requests to be discharged.

GEORGE E. PRATT,
W. E. KERSHNER,
E. H. RISLEY,
WILLARD H. BUNKER,
STORER W. BOONE,
T. A. FOSTER,
R. L. MITCHELL,
S. J. BEACH, *Chairman.*

CHAIRMAN BLISS: Thank you, Dr. Beach. You have heard Dr. Beach's report and his suggestions. What is your pleasure relative to disbanding or discontinuing the Committee?

DR. KINGHORN: I move that the Committee report be accepted, but that the resignations be refused.

This motion was duly seconded and was carried.

CHAIRMAN BLISS: We shall now have a report of the Amy W. Pinkham Fund Committee, by Dr. Foster.

DR. FOSTER: Mr. Chairman and members of the House of Delegates. For your information, I should

like to report that Amy Pinkham left $20,000 to be used for under-nourished and tubercular children in the State of Maine. The Executor, Mr. Mott, put the will through the Probate Court of Cumberland County, naming as his first choice the new organization to handle the proceeds of the funds, and naming as his second choice the Maine Public Health Association. The Judge of Probate, in considering the will, decided that the money could properly be deposited with the Maine Public Health Association, with the distinct understanding that the $20,000 or any income thereof should not be spent without the advice of a committee named by the President of the Maine Medical Association.

Your President has named the following Committee: Drs. Foster, Chairman; Virginia Hamilton of Bath, Guy E. Dore of Guilford, Albert Carde of Milo, Claire S. Bauman of Waterville, P. L. B. Ebbett of Houlton, and John F. Hanson of Machias.

The money is safely in deposit with the National Bank of Commerce of Portland, and I was told a week ago that the income of the fund was about $475.00.

The Committee, therefore, have not met to determine the amount of money to be used, because the amount was not considered sufficiently large.

It is the intent of the Committee to meet with Judge Stearns, the President of the Maine Public Health Association, and establish some policy for which the fund may be used.

Chairman Bliss: What is your pleasure, Gentlemen, regarding this report?

Dr. C. Harold Jameson, Rockland: I move that the report be accepted and placed on file.

This motion was duly seconded by Dr. Plummer and was carried.

Chairman Bliss: The Maine Physicians' Service, a prepaid medical plan, submitted by a special committee appointed by the Council, October 24, 1943, consisted of the following members: Drs. John O. Piper, Chairman; Currier C. Weymouth, Warren E. Kershner, Frederick T. Hill, E. Eugene Holt, and myself.

The Chairman of that Committee will now report to you.

Dr. Piper: Mr. Chairman and Members of the House of Delegates. You have heard my report from the Council regarding this matter. The thing that I would like to call to your attention is this; that we did go through the different plans from different states, and the thing that finally was settled upon was that if we did anything we favored uniting with the Blue Cross of the State on some plan.

Of course, the main drawback to that plan was that the Blue Cross absolutely refuses to do anything with it unless the Maine Medical Association, as an Association, sponsors the whole thing. That forced us to make these two resolutions which I should like to read to you again.

"At the meeting held at Waterville on Sunday, February 20, 1944, it was voted that the Committee endorse the idea of a prepaid medical care and surgical care plan, believing that this is a progressive step in the interests of the public health of the people of Maine, and that the Committee so report to the Council of the Maine Medical Association."

I think that your Committee felt and does feel that there is a need in certain of the earning groups to protect themselves so that they can budget their funds and still have adequate medical care. This was drawn up.

"Secondly, it was voted that the Committee advise the Council of the Maine Medical Association to cooperate with the Hospital Service of Maine in providing such a plan, which shall endeavor to maintain the highest possible standards of the professional services of physicians, and that if the Associated Hospital Service in Maine does not see fit to enter into such a working agreement, that the Maine Medical Association will insure such high standards of service that will endorse the general idea of the plan, to the end that the members of the Maine Medical Association be encouraged to participate as individuals."

I think that means just this: That if we have to unite, if there is no other way that we can produce a prepaid medical plan without endorsing it, and taking in the osteopaths of the state who will, perhaps, get the benefit of the endorsement, I don't think the committee really favors the plan. But, they did favor some sort of a prepaid medical service plan, and I would like to submit that to you and I think whether you think about it or not, you are going to be forced to think about it in a short time.

Chairman Bliss: You have heard Dr. Piper's report. Now, we should like to hear from some of the delegates on the question of prepaid medical care. The Council, as you know, was unwilling to accept the responsibility of making a decision in this matter; even though it could have done so, it was unwilling to take this great responsibility.

It is, therefore, before the House of Delegates for discussion and for settlement as to what our attitude shall be toward a prepaid medical care plan. We are open for discussion.

Dr. L. H. Smith, Winterport: Would it not be a good idea to call upon the delegates of the various societies to see what action was taken by those societies?

Chairman Bliss: I will call upon the delegate from Penobscot first.

Dr. Smith: Well, at our meeting, the problem was discussed, and it was voted to reject that plan. It was suggested, however, and Dr. Ames, if I don't state this right, I wish you would tell me. But perhaps I shall read it and then it will be straight, because it was my impression that it was suggested that we contact some commercial or insurance company to see what their plan might be. But, this is the report of the meeting as gotten up by the Secretary.

"At a meeting of the Penobscot County Medical Society, held Tuesday, May 16th, it was voted to instruct our delegates to vote against the proposed plan for prepaid medical care, which was presented by the Associated Hospital Service. It was further voted to suggest that the so-called commercial insurance companies be approached relative to proposing some acceptable plan for prepaid medical care."

Now, would it be an inopportune time, perhaps, to wander into barren ground with just a few of my personal observations?

Chairman Bliss: It is very opportune.

Dr. Smith: This is my own personal idea. I was glad to find some other individuals with the same ideas, and I think it was in the May issue of the Journal that a splendid article was written by a Portland man, the name escapes me for the moment, but he went on to say, in a few brief words, that no plan would be successful in the State of Maine unless the majority of doctors were in favor of it. I am one hundred per cent against Federal control. But, I think if we work hard to get some other plan going and submit some other plan, we will be working ourselves into a similar situation.

The medical care in Maine hasn't been too bad, considering the paucity of physicians, and I do believe that if any plan should be devised, the public should be the ones to organize themselves or get these insurance ideas and then possibly submit it to our organization. The more we agitate this, the more we say that we will have to offer something in opposition to the Wagner-Murray-Dingell Bill, and there you are.

I don't see any reason why we have to offer any-

thing except possibly the hard work we have always done and certainly no bill or no system of medicine can be successful unless the majority of physicians accept it. I, for one, am strongly opposed to Federal control of medicine. I doubt if I should ever link myself up with any prepaid plan, if it was sponsored by the national government. But, you know, at our ages, we don't have so much to think about, but I am thinking more about the younger men and I think we should be mindful of their earnings and the manner in which they are able to rear their families and the lives which they shall live.

We cannot, as a whole, be forced into any plan, other than the plan of hard work and good service, which we have always maintained in this State.

I would like to shake the gentleman's hand who wrote that article I spoke about. It expresses my sentiment perfectly.

CHAIRMAN BLISS: Thank you, Dr. Smith. Is the delegate from Androscoggin County here?

DR. RALPH A. GOODWIN, Auburn: At the meeting of the Androscoggin County Medical Society, no definite action was taken on this matter, because it was felt that they were not sufficiently informed to instruct the delegates as to any action that might be taken. It came up, well, I won't say suddenly, but they were uninformed as to the details of the plan, although Dr. Carter gave an explanation at the time, and they haven't had any subsequent meeting.

The question has been discussed somewhat and some of the men from the county felt that they had a question, which was this. Was this proposal something constructive, to take the place of the so-called Wagner-Murray-Dingell Bill? They felt that if it was necessary to do something constructive in place of that, they would be willing to take action. But there was some doubt as to whether this was necessary in order to oppose that bill—whether we should oppose it in a negative way and simply veto the bill by whatever influences we had, or whether it was necessary to form some constructive plan, as suggested. So that is all I have to offer at this time as a delegate.

CHAIRMAN BLISS: Those are the questions that perplexed the Committee throughout the year.

Now, we shall hear from the delegate from Aroostook, Dr. Swett.

DR. CLYDE I. SWETT, Island Falls: The Aroostook County Medical Society has not had a meeting since the proposal of the plan, and so the Aroostook delegates also come uninstructed to this meeting.

CHAIRMAN BLISS: The Cumberland County Delegate?

DR. C. EARLE RICHARDSON, Brunswick: We had two meetings of our county society and reports of the meetings were sent to each man in the county. About two weeks later, instructions to the delegates were to vote against it.

CHAIRMAN BLISS: Franklin County, Dr. Pratt?

DR. GEORGE L. PRATT, Farmington: Three or four members of the Franklin County Society were inclined to support any recommendation made by the Council. But, I think that the feeling seems to be that Franklin County shouldn't go into anything of this kind, unless the large majority was in favor of it.

CHAIRMAN BLISS: Hancock County has no representation here, I believe. Kennebec County delegate?

DELEGATE FROM KENNEBEC COUNTY: The Kennebec, Waldo and Somerset Counties had a discussion on this point, and I believe that one of the important points of the discussion was: That there should be no relationship between our thoughts in this matter and the Wagner-Murray-Dingell Bill, and that this measure should be considered on its own merits, and if the Society voted to accept the idea that there should be an insurance plan, it should not be the type of plan which was presented by the Council.

CHAIRMAN BLISS: We shall now hear from Knox County.

DR. JAMES CARSWELL, Camden: The delegates from Knox County were instructed to vote favorably regarding the plan in general, recognizing, of course, the necessity for further work on it, and clearing up some controversial points.

CHAIRMAN BLISS: The Lincoln-Sagadahoc County Delegate?

DR. JAMES W. LAUGHLIN, Newcastle: Our Society voted that the Delegate be instructed to follow the subject closely, but we were uninstructed to vote for or against it.

CHAIRMAN BLISS: Oxford County, Dr. Stanwood.

DR. HAROLD W. STANWOOD, Rumford: Our Society, after some thought and study of the matter, instructed me as a delegate to vote against this matter, and although the county was not well represented as far as numbers went, and many of the men present did not vote, I think it was not fully understood, and they would like to hear a little more about it.

CHAIRMAN BLISS: Piscataquis County, Dr. Stuart.

DR. RALPH C. STUART, Guilford: Our Society rejected this entirely and made a provision that they wished the hospital part of it could be rejected also.

CHAIRMAN BLISS: Then they evidently understood it. Somerset County, Dr. Stinchfield.

DR. WALTER S. STINCHFIELD, Skowhegan: Our Society said they would be in favor of some prepayment medical service, but they did not think it should be run or financed by the Society in any way, but by some insurance company or some other company.

CHAIRMAN BLISS: They did not instruct you to support the hospital association idea?

DR. STINCHFIELD: No.

CHAIRMAN BLISS: Nevertheless, they liked the plan. Now, Dr. Stevens of Waldo County.

DR. CARL H. STEVENS, Belfast: At a meeting of the Waldo County Society, on June 6th, held to discuss the prepaid medical service plan as laid out by the Blue Shield and presented to the Maine Medical Association, after considerable discussion, it was voted to instruct our delegate that this Society is opposed to the plan for the following reasons:

First, the members most interested, that is, having the longest prospective practice, are mostly in the armed forces at the present time, and they are not able to express an opinion on the plan.

Secondly, we are opposed to any plan which necessitates regimentation of physicians and restrictions of their freedom in the practice of medicine.

Third, the proposed plan is a step towards state medicine, of which we are unanimous in our disapproval.

Fourth, existing similar plans, in other words, notably California, have proven impracticable.

Fifth, the fee schedule offered does not meet the approval of the Society.

And, if I may add one personal touch, I have a feeling, where I practiced for thirty-one years in a rural community, in this matter. We have 186 men, if our JOURNAL is right, who are coming back, but the number of men coming into our rural communities grows less and less every year, except for the osteopaths. Now, it is my personal opinion that if we, as a Society, want to do something for the people of Maine and carry out Mr. Hildreth's idea, that we must take care of the health of the people, if they are going to stay in Maine, particularly young people. So that what we need is a good medical school in the State of Maine for general practitioners, not specialists, and, with all of the present talent in Portland, Lewiston, Waterville and Bangor, there is no reason why we cannot have one.

CHAIRMAN BLISS: Washington County. I understand they rejected the plan.

York County, Dr. MacDonald.

Dr. James H. MacDonald, Kennebunk: At our last meeting, which was in April, there wasn't any discussion; consequently, we came here without definite instructions.

Chairman Bliss: The question is now open for general discussion. We should settle this matter here, you know. This is the Court of last resort, with regard to the prepaid medical care plan.

Dr. Kinghorn: At the present time, we have several so-called schemes to take care of prepaid medicine or whatever you have a mind to call it. The companies are putting them out. I had a case a short time ago where they paid the hospital and everything, from the time he came in until he left. But I never got a cent of it. Is this scheme going to turn it all over to the patient?

Chairman Bliss: I believe that the Commercial insurance companies do turn it over to the patient.

Dr. Kinghorn: We don't want anything to do with it.

Chairman Bliss: In the proposal of the Maine Physician's Service, they do not turn it over to the patient, but they pay the doctor direct and any scheme which we have considered as a Committee has paid directly the bills to the persons who render such bills for services.

Dr. Kinghorn: I understand the Blue Cross have two schemes; one to pay hospital bills, and another where they pay everything, but they don't pay the doctor; they pay the patient.

Chairman Bliss: The Blue Cross is the prepaid hospital plan, but it does not and never pretended to pay physicians. Is that not true? Those are two separate schemes. They have in Massachusetts, the Blue Cross and the Blue Shield. The proposal which the Associated Hospital Service makes is to carry these two accounts absolutely separately. They are to be administered separately, and they shall have nothing to do with each other; there is no function interlocking the two schemes.

I feel that in view of the number of delegates who have come uninstructed, and who have not been informed, as they say, regarding this scheme, although it is very difficult to understand how they can avoid absorbing this information inasmuch as it is on the air and it is in the press and it is everywhere else, yet I feel that because so many have come uninstructed, we should have some explanation of this scheme. Therefore, I am going to ask Dr. Piper to explain it as it now stands.

Dr. Piper: Mr. Chairman and members of the House of Delegates. I can't do anything more than to say what I said before, and refer you to the two motions that we made at Waterville, on February 20th.

I can explain in a few minutes what I think should be decided before we do anything. Do we think that the people of Maine need some form of insurance, or whatever you want to call it, so that they can budget their medical care better than they can at the present time? I think that is the question to settle first.

Dr. Swett: If I might have a personal thought in this meeting, it would seem too bad to me that this House of Delegates should meet here today and not have more definite opinions and ideas expressed. I feel that the people of Maine are rather kindly disposed toward the insurance method of paying their expenses in medical care and other things, and if we don't grab hold of this thing one way or another, we are definitely putting ourselves out on a limb.

The thought comes to me, that it is entirely possible, for example, with the great influx of osteopaths into the state and the tremendous hold they have on the rural sections, for such a plan to be proposed through the osteopathic association, as a result of the Maine Medical Association making no move whatever, it might cast a dark, black aspect on our interest in the people; even though we here really do have them at heart, the feeling outside might be entirely different, and it might do us a considerable amount of harm.

Although our county society has not done much in the line of insurance, I do feel that this is the place for the delegates to be instructed in such a matter, or to have discussion sufficiently strong so that they can return to their societies and let the societies get their feet placed on the ground with the thoughts that we are trying to express here today.

Dr. Plummer: The thing that presents itself to me is not so very complicated. I say there are two or three questions that you might answer here today. It seems to me, again, that the answers are not too hard.

One question is merely whether we, as a society, as an organization, are willing to take a position so that any member who wants to do so may enter into a contract with any insurance company that wants to do it. Or, are we opposed to doing this thing at this time?

The question as presented here is only whether this organization expresses itself as agreeable to form an insurance group with some company.

Now, the second question, I believe is this. If we are agreeable to it, are the fees satisfactory, and if the fee schedule as laid out is not satisfactory, let us say so and in what respect? In fact, that might be left up to each physician to say whether the fees are on the whole satisfactory to him, although I may call attention to any who are not familiar with the bill as brought here that, generally speaking, the fees as prescribed there — assuming they are agreed upon — are supposed to be fair fees. In particular cases, it might be that more attention was required from a physician or a surgeon than would ordinarily be the case on the average case, in which case there is opportunity given to the physician so that the physician and the patient may agree to a different sum, but the balance of the fees there shall be paid by the patient himself, and not by the association.

It is stated in there further, as I recall it, that it is expected that not over 20 per cent, or, to put it another way, that 80 per cent would fall within the list of fees there stated, and for the remaining 20 per cent, there should be special arrangements made.

The third question that arises is this. Assuming that we agree to endorse the general proposition, and if we sort of generally assume that the fees are fair, the other question comes to mind as to whether we should endorse any particular insurance company.

If we endorse the proposition today or any other time, it doesn't follow that any man who says "No" now cannot change his mind.

What do I care whether the rest of you go in or don't go in? What do you care whether I go in?

The thing, as it presents itself to me, is not so complicated as on the face of it. Are we willing to endorse it if the fees are satisfactory? Should we pick out some insurance company, the Blue Cross or anybody who comes along? Those are questions to be settled.

Chairman Bliss: Thank you, Dr. Plummer. We would, that it were as simple as you have made it seem.

That disposes of commercial insurance companies and gives us a free hand, as we have had right along, in regard to which insurance company. But that is not the question, unfortunately. We have not so far considered our relationship to commercial insurance companies, and it is not so simple as you find it to be. I was hoping that Dr. Piper would go into this from the start, because he was on the committee and grew into this knowledge gradually, and I take it he assumes that you all know that the Associated Hospital Service in Portland, which we shall hereafter call the Blue Cross for convenience, has an Enabling Act given it

by the State Legislature, under which provision it is able to insure families, individuals, against illness, insofar as hospital care is concerned, and there they stop. Now, if we are to start a prepaid medical care plan, we must appear before the Legislature of Maine and seek an Enabling Act, in which case if it is to be obtained. it will probably be administered by the Insurance Commissioner of the State of Maine; that is, it is sometimes so administered.

The Associated Hospital Service in Portland has already an Enabling Act, and it has an Executive set-up, with sufficient office help, and because they have had experience in dealing with the public through their development of the Blue Cross Plan, they proposed, or we proposed to them, I don't know which one made the proposition first but that is immaterial, that they might possibly administer a plan for prepaid medical services. And so Mr. Webb, who heads that organization, was asked to bring out such a plan, a proposed contract. He did so, and that contract has been in the hands of nearly every practitioner in Maine. The provisions of that proposed contract may or should be familiar to you all, as well as its schedule of fees and its manner of administration. It is a question of whether you wish to go before the Legislature, obtain an Enabling Act for the medical profession of the State of Maine to conduct a plan of prepaid medical care by yourselves, and exclusive of all cults, or whether you wish to join with the Associated Hospital Service, the Blue Cross Plan, as proposed in that contract submitted by Mr. Webb, in which individuals and families are insured against illness, surgical, medical, obstetrical.

Now, that plan was proposed to the Committee; it was considered by the Council; the Council passes it on to you.

Are you in favor of a prepaid medical care plan? Do you believe that the people of Maine need a prepaid medical care plan? Do you believe that the quality of medical care may be better or the relationship between patient and physician better? Do you believe that any part of our present set-up can be improved by joining in with such a scheme? If so, do you favor entering a contract with the Blue Cross in Portland for them to administer it? Their terms are: Equal treatment for osteopaths and M. D.'s. The osteopath who treats a patient and submits his bill gets his pay from the new organization.

Now, they wish, and insist upon having a medical director chosen from among our number. This medical director shall approve or disapprove of all claims or at least all questionable claims coming into that office for payment. In other words, he not only approves of your bill and my bill, but he approves the bills from the osteopaths, as well. Does he, by so approving those bills, approve the whole osteopathic scheme? That is for you to decide.

They also insist on assistance in administration, in making decisions, by a board of governors, trustees or directors, chosen from among our members, as well. So that on our stationery, as it goes out, our Blue Shield Plan, will be the names of two or three M. D.'s and on the bill heads, as the osteopaths are paid, our names appear there also.

Now, the question is, do we want that set-up? I have told you the mere rudiments of this offer or this plan, for the benefit of those who say they do not understand that part of it.

The Associated Hospital Service, so far as I know, stands ready to go on with this plan the moment we approve it. The question is: Do you believe this plan is better, or what plan do you believe is better? These are the things that must be settled here today, or these must be acted upon according to your pleasure. Does some one wish to make a motion regarding this matter?

Dr. Stanwood E. Fisher, Portland: I would like to discuss this for a moment. I am very much against this plan. In the first place, the relation of the patient and the physician will deteriorate very, very much. We have all done operations, and if the patient had no money, we did them just the same. If they had money, then of course, we would like to enjoy a good fee. We never turned a patient down because of the fee. If we knew a patient needed medical care, some one took care of that patient.

Another thing, I don't think we doctors want to associate ourselves with osteopaths, and to agree with anything they would do. As I understand it, the Blue Cross wants to take in the osteopaths. I don't know if the osteopaths do work for nothing. But we all do it and are glad to do it. If the patient hasn't any money, then the osteopaths don't bother with such a patient. But the doctor will treat a patient with no money.

I think that the people of Maine get very good treatment under the present plan.

Dr. Stuart: I met a superintendent, the superintendent of the Rumford Hospital, before coming here and he informed me that there is a mutual benefit association in Rumford that takes care of this situation. I would have mentioned it before, but you suggested that the insurance companies should all be within the state, or I heard that suggestion somewhere. This association is from Iowa, and they have a plan which is much better than the Blue Cross and has been working over there, and I wondered if there were any doctors from that district who could tell us about it. If not, I will give you the details, such as were given to me. However, there may be a delegate from Rumford here.

Chairman Bliss: Is there any one here who knows anything about the mutual plan?

Dr. Albert P. Royal, Rumford: About four years ago, the Oxford Paper Company Welfare Committee decided that they wanted a prepayment plan for employees. They studied many plans. The ones that stick out in my mind are the ones in Timmins, Ontario; it functioned three years and finally folded up, paying somewhere in the vicinity of twenty-five cents on the dollar. They discussed the various plans with the staff of the Rumford Hospital, and the staff, at that time, felt that the Blue Cross was the acceptable thing, even though it just covered hospitalization. On their own initiative, they endorsed a plan with the Mutual Benefit Association of Iowa, and put it into the local mills. That plan offers both hospitalization and a restricted fee schedule on surgery; it offers maternity care, hospital expenses for maternity care; it pays for house visits, office calls, and special nurses.

Of course, while the plan is all inclusive, it is a little prohibitive to take all of the possibilities offered to the average working man. Hospitalization alone, which pays 17 days, at the rate of $4.00 a day, except for alcoholic and insanity cases; it pays the surgeon roughly $75.00 for any laparotomy; there are various schedules for fractures and for minor surgery. It pays $100.00 for the injection of antitetanic serum in the spinal cord. And there are other absurdities which are very pleasing to the layman's eye, but which are not common practice; the list is restricted, and it pays nothing except what is listed in the policy, with the provision that any operation not above listed will pay $5.00. Therefore, for a thyroidectomy, they will pay $5.00.

During the first two and a half years, they campaigned very strenuously at the mill. At the end of that time, they had succeeded in signing up two-thirds of the approximately 2,500 employees. At this time, they took over the so-called chronic clause; that is to say, if any employee of the mill had hernia before he took out his policy, they paid for the hospitalization

and paid for the surgeon. If the time ever arrives when the employees insure two-thirds of their dependents, the chronic clause will also be removed from the dependents. But, to my mind, after four years if they haven't been able to get two-thirds of the men to sign up for their families, there is something wrong. Of course, it is true that it is a big help in many cases, but most of the ones who need it do not have it.

Dr. Kinghorn mentioned opposition to commercial companies because the company paid the patients. That is true with this company, except that we have gotten around that because of the fact that we have the patient sign an assignment when they sign the application for payment of bills which have been contracted, and I know of no instance where the patient has refused to sign the assignment at the same time that he signs the application for payment. I think that overcomes that point satisfactorily.

The one question that came up during our County meeting was this. Who is going to pay for all of this? Now, I cannot give you the exact rates of this policy I have been speaking about, in the terms previously mentioned, but it does cost approximately $32.00 a year for a man, wife and any number of children, regardless of how many. The fee for surgery runs approximately 90 cents a month, around $10.00 a year, putting it up in the neighborhood of $40.00 or $45.00 a year for these plans. That is Plan A and Plan B and does not include payment for house visits, office calls, special nurses, etc. We have all discouraged that, because it is prohibitive.

Also, at our county meeting, we were privileged to hear a few words from Dr. Crimmins, who is now at Hebron; he was a member of the White Cross in Massachusetts. I don't remember the exact details, but he got $2.50 for all the work that he did as a member of the organization, and he didn't state how much he did, but he did give the impression that he had done considerable.

The financial end of it has not been discussed here. You know the schedule; I believe it is approximately $12.00 a year for the plan. But, where is the money going to come from that is going to pay all these bills, until a vast majority of the people of Maine have signed up?

Seeing this work in our community, I have felt that the majority took the plan, not because they thought it would help them from the viewpoint of improved service, but because it seemed to be the thing to do, with pressure from the union and the agents soliciting in the mill. But, after four and a half years, there are still less than two-thirds of the families signed up. And, another thing, the employees who have left the mill have let their policies lapse.

I might say that the policies are also available to anyone in the community.

This is operated by a commercial company, and it is a profit-making organization.

I might say, also, that perhaps five and possibly ten per cent of the members of the community outside of the mill have taken the policy, and if they did not take the plan, it would not pay.

CHAIRMAN BLISS: We shall be glad to hear from anybody else on what to do with the prepaid medical care plan.

(To be continued in the November issue)

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Penicillin in the Treatment of Sulfonamide-Resistant Gonorrhea
A Report of 191 Consecutive Cases

By Captain Russell Wigh, and Captain George I. Geer, Jr., Medical Corps,
Army of the United States

This report is a review of 191 consecutive cases of sulfonamide-resistant gonorrhea treated at a Station Hospital. Practically all of the patients were referred for penicillin therapy from surrounding medical installations which had managed them with sulfonamides.

A patient was considered sulfonamide-resistant if he had not responded to the following minimal dosage schedules: one duty course of sulfathiazole or sulfadiazine consisting of 1 Gm. of the drug four times daily for five days (20 Gm.) plus one hospital course of either drug, beginning with 4 Gm. followed by 1 Gm. every four hours, day and night, for five days (33 Gm.)

The average duration of disease was 1.7 months, varying from two weeks to twelve months. The average amount of sulfonamides a patient had received was 88 Gm. In several instances individual patients had received more than 150 Gm. of sulfonamides.

Eighty-three per cent of the patients had a purulent or muco-purulent urethral discharge. In 16 per cent the discharge was mucoid, while in the remaining two patients no urethral discharge was noted. Epididymitis or prostatitis was present in 23 of the patients; one patient had an acute gonorrheal arthritis, another a peri-urethral abscess. In those instances where Gram negative intra-cellular diplococci could not be demonstrated on smear from urethral or prostatic exudate, positive prostatic or urethral cultures were obtained.

Mode of Administration and Schedules of Treatment

One hundred thousand Oxford units of the sodium salt of penicillin were dissolved in 30 cc. of sterile distilled water. Individual injections of 10,000 units in 3 cc. of water were administered intra-muscularly into the gluteal region through a 1½ inch, 20 gauge needle. The solution was stored under aseptic conditions in a refrigerator between injections. The maximum period of use of any preparation was twelve hours.

Two schedules of treatment were used. All patients initially received a total of 50,000 Oxford units. This was administered in five doses at three-hour intervals. The second schedule was used only for those patients who were

clinical failures after the first schedule. It consisted of the injection of a total of 100,000 units in ten individual hourly doses. Patients not cured by these two schedules were transferred for fever therapy.

Drug Toxicity

In no instance was a systemic reaction seen following the intra-muscular use of penicillin which could be attributed to the drug. Patients occasionally complained of transient tenderness over the site of the injection; this was never felt to be more severe than the pain that would be present following the injection of a similar quantity of distilled water. It is believed that the progressive reduction in impurities in the preparation of the drug accounts for the absence of side-reactions noted in this series as contrasted with earlier experience.[1]

Results

The response to the injection of penicillin was dramatic. As early as the third injection, patients volunteered that they had had a marked reduction in the amount of discharge and a change in its character. The average patient responding favorably to 50,000 units was returned to duty the morning of the fourth day following the completion of therapy. During this interval, four consecutive daily urethral smears, each taken prior to morning urination were obtained. If no discharge was present at the meatus, a sterile swab was introduced and rotated gently. Cultures were taken from those patients in whom the laboratory reported extracellular Gram-negative diplococci on the routine daily urethral smear.

Response to 50,000 units.—One hundred and seventy patients (89 per cent) had satisfactory results with 50,000 units. Seventy-nine per cent of these patients had no urethral discharge on return to duty. The remainder had a slight watery or mucoid discharge, bacteriologically negative, predominantly noticeable on arising in the morning. This was not felt to be significant. The presence of a mucoid discharge following penicillin therapy has been previously noted in the literature.[2]

It is interesting to note that of the 25 patients with gonorrheal manifestations besides urethral, 18 of them, including the patient with gonorrheal arthritis, were apparent cures on this schedule. The patient with acute gonorrheal arthritis showed rapid improvement following penicillin, and was symptom-free twenty-one days after treatment. However, only 10.6 per cent of the total patients treated successfully with the first dosage schedule had such complications as noted above.

Twenty-one patients (11 per cent) were bacteriological failures after the administration of 50,000 units of penicillin. In 19 of these patients the discharge, after a transient cessation or reduction, again became purulent in character. In the other two patients, the discharge, which was initially described as slight, was not appreciably altered.

Two-thirds of these patients had relapsed bacteriologically by the end of a week, the majority by the fourth day. Twenty-eight and six-tenths per cent of them had had gonorrheal complications prior to initial penicillin therapy. The patient with the peri-urethral abscess not only was a failure on the 50,000 units but developed an acute epididymitis thirty hours after the completion of the first treatment schedule. One other patient had an appendectomy the day following his treatment with 50,000 units. He was catheterized twelve hours post-operatively and shortly thereafter had a relapse with a purulent urethritis and an acute epididymitis.

These 21 patients received 100,000 units of penicillin by the treatment schedule previously described.

Response to an additional 100,000 units.—Nineteen of the patients so treated responded favorably. Two patients, both white, were failures. Both had prostatitis; one had had gonorrhea for twelve months.

Thus, 98.95 per cent of the entire group responded favorably to the first treatment schedule alone or to a combination of both schedules.

Follow-up Observations

In 48 unselected cases follow-up reports, of examinations after periods of two weeks or longer, showed no evidence of relapse; 23 additional patients were asymptomatic and bacteriologically negative at periods seven to fourteen days after treatment. Although follow-up reports of two weeks or longer were obtained

in only 25 per cent of the patients who were returned to duty as apparent cures, the authors are confident that this is a true reflection of the efficacy of the therapy.

The special circumstances, both military and geographical, were such that only at this hospital could sulfonamide-resistant cases of gonorrhea receive penicillin therapy, and consequently, failures to the first treatment schedule must necessarily have returned here for the second. This is substantiated by the fact that six patients, treated with 50,000 units and sent to duty, subsequently relapsed and were returned to this hospital for the second course.

Discussion

The high incidence of complicated gonorrhea in this series as compared with present general military statistics is readily accounted for by the fact that all of these patients were unresponsive to sulfonamide therapy and therefore had their infections for relatively long periods—an average of seven weeks before cure. Although it was noted that there was no appreciable difference in the duration of the disease in that group responding to 50,000 units as compared with those receiving an additional 100,000 units, the latter group of patients had, in 28.6 per cent of the instances, already acquired complications of gonorrhea, whereas there were complications only in 10.6 per cent of the first group. One can anticipate, then, that the treatment of acute or relatively recent gonorrhea without complications will show even greater success with the smaller treatment schedule.

Since complications of gonorrhea increase with the longevity of the disease, it would appear to be necessary to reduce the duration of therapy with sulfonamides in order to effect a reduction in the number of patients needing more than 50,000 units of penicillin for cure. This is an important consideration in view of the present pressing need for the conservation of the drug.[3]

Schedules of treatment were in accordance with directives from the Office of the Surgeon General. The selection of a volume of 3 cc. of distilled water as a diluent for the 10,000 unit dose was arbitrary. A more concentrated dose (10,000 units in 2 cc.) would have been undoubtedly just as effective and therefore more desirable.

It was realized that by returning a patient to duty on the fourth day after penicillin therapy an occasional relapse would occur after he had left the hospital. However, it was anticipated that these relapses would be few, and due to military expediency it was desirable to make the hospitalization period short after treatment with penicillin. Our present view is that a further reduction in man-day loss can be effected by returning a patient to duty immediately following the first negative urethral smear if he is symptom-free or if he has a nonpurulent discharge.

Indeed, since the toxic reactions to penicillin therapy are reportedly rare and of a mild character, the use of the drug in sulfonamide-resistant gonorrhea as an out-patient procedure is feasible.

Summary

1. Of 191 consecutive cases of sulfonamide-resistant gonorrhea treated with 50,000 units of penicillin in five divided doses over a twelve-hour period, 89 per cent were considered cured.

2. Retreatment of the 21 failures with an additional 100,000 units resulted in cures in 98.95 per cent of the entire group. Two patients did not respond to a total of 150,000 units.

3. Although 50,000 units of penicillin will cure most patients with gonorrheal manifestations other than urethritis, a large proportion of those requiring an additional 100,000 units have complicated gonorrhea. It is not possible to predict which patients will need larger dosages than 50,000 units.

4. Proportionately more negro than white patients are cured with 50,000 units of penicillin.

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The Physician and the Control of Gonorrhea in the Armed Forces

By Edward M. Cohart, Captain, M. C., A. U. S., Venereal Disease Control Officer, First Service Command, and O. F. Hedley, Senior Surgeon, U. S. P. H. S., Liaison Officer, First Service Command

Venereal diseases, despite phenomenal advances in prevention and treatment, continue to be a major cause of man days lost from duty in the armed forces. Practically every case in military or naval personnel occurs as a result of sources of infection among civilians. The discovery and treatment of cases of venereal diseases in the acute, highly infectious stages is probably the most important means of preventing the spread both among civilians and members of the armed forces.

Although the coöperation of civilian physicians has generally been satisfactory, nevertheless there has been too great a tendency to fail to diagnose and treat gonorrhea in the female, except on the basis of positive laboratory findings. This applies particularly to females named as contacts of known cases of gonorrhea. It is axiomatic that the male urethra is the best culture medium for the incubation of the gonococcus.

Ideally, the diagnosis of gonorrhea, especially in the female, should be confirmed by laboratory procedures. Practically, in many localities where adequate facilities for laboratory confirmation of the diagnosis of gonorrhea do not exist, the diagnosis of gonorrhea must be made on the basis of history and clinical findings.

An acute urethral discharge in the male can almost always be diagnosed adequately by means of the Gram-stained smear. In chronic urethral discharges and as a test of cure in the male the diagnosis by smear is less dependable. In such cases the employment of cultural methods for the isolation and identification of the gonococcus will yield a much higher percentage of positive diagnoses.

In the female the Gram-stained smear is of much less value than in the male as a means of diagnosis. A positive smear often can be taken at its face value. A negative smear, or even several, does not mean freedom from gonococcal infection. Experience has shown consistently that many females in whom smears of the genital secretions have been reported as repeatedly negative for the gonococcus have been proved to have gonorrhea by culture of this same material. Often more than one culture must be taken before positive findings can be obtained. The single culture, while more dependable than the single smear, by no means falls into the category of diagnostic procedures with one hundred percent efficiency ratings.

Material for cultures and smears should be obtained from the cervical and urethral canals. Care should be taken to ascertain that a douche has not been used for at least twelve hours previously. The cervical material should be obtained by a cotton applicator, after removing the mucous plug at the opening of the cervical canal. The speculum may be used to gently aspirate purulent material from the cervical canal. The lower end of the urethra should be gently massaged against the pubes bone to obtain material from Skene's glands. At least three smears or cultures should be taken to determine the effectiveness of treatment, one of which should be obtained after menstruation.

In gonorrhea as in any other disease it is not the laboratory but the physician who makes the diagnosis. Negative laboratory findings do not rule out disease. In the many localities where facilities for the cultural demonstration of the gonococcus are non-existent, the diagnosis of gonorrhea must be made on the basis of what the physician hears, what he sees and what he knows. The physician does not hesitate to make a diagnosis of measles on the basis of history, clinical findings and his knowledge of the disease even in the absence of laboratory isolation of the measles virus. The physician should not hesitate to make a diagnosis of gonorrhea on the basis of history, clinical findings and his knowledge of the disease even in the absence of laboratory isolation of the gonococcus. The complications, both medical and social, of untreated gonorrhea demand early diagnosis and treatment.

Objection will be raised to the diagnosis of gonorrhea on clinical grounds. It will be said

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The Doctor's Laboratory

A. J. Fuller, M. D.,* Pemaquid, Maine

Recently, when so many articles are being written by proponents of the Wagner Bill condemning the medical services given to the indigent and lower-income groups, one aspect is constantly stressed, and is the only thing they have mentioned which could be of value to the patients—namely, a lack of adequate laboratory facilities by the average physician.

This is admitted, but the medical profession itself is rapidly taking care of this lack. Many of the older doctors, who for some reason have not become familiar with laboratory aids, are dying or retiring in considerable numbers each year; and the young men, fresh from college and interneship, realize the need of confirmatory evidence, by the laboratory, for their diagnoses. This process of evolution, would, in a fairly short time, take care of this deficiency.

A laboratory for an average physician does not need to be elaborate or very expensive to furnish much valuable aid. It should be well-lighted, well-heated, and with enough room to work without being crowded. It should start with a few pieces of apparatus and be developed along whatever lines interest the doctor most. It is not the size of a laboratory that counts, but whether it is used with judgment, that makes it valuable.

Any high-school girl of ordinary intelligence, working under a doctor's direction, can do all the necessary tests providing she is made to realize the fact that a test, unless it is done with *utmost* accuracy, is not only of no value, but is a source of real danger.

Any urinalysis outfit, brought from a medical supply house, is probably the best arrangement for that part of the laboratory, and much information can often be gained by routine examination of every patient's urine, until at least you are sure that their urinary tract is free from suspicion. A urine concentration test is one of the best kidney function indicators, and requires no apparatus except a urinometer. Most physicians have a microscope and can do an accurate microscopic examination, without a centrifuge, by taking more time for each examination.

A Sahli, counting chamber, pipettes, and some slides will enable one to do infinitely better work in practically every case of blood dyscrasia. A Westergren tube can be used for sedimentation rates without buying the usual holders which are apt to be in the way. If your shelf happens to be about one foot above the laboratory bench, an old clock spring three-quarters of an inch wide and eight inches long may be straightened, the ends heated, and holes punched—one for a small nail or screw, and the other large enough to admit the rubber top from a vaccine bottle. This is nailed, or screwed, under the shelf, and, by means of a level to adjust it first, the Westergren tube, which is approximately eleven and three-quarters inches long, is held in a perpendicular position on the bench. Markings are made under the shelf to indicate the proper position of the spring when the tube is in position. Then a small hole is drilled in the bench where the tube is pointed, and the cap from a Lederle's liver vial put in it to act as a base for the tube. This makes a satisfactory holder, is pushed back out of the way when not in use, and is only one of the many things which can be improvised to make a laboratory more workable and more personal. Several of these would take up no more usuable space than one.

The blood chemistry examinations are simple, but require a colorimeter, and it does not pay to buy a cheap one. With these basic things, the only articles further necessary are a few extra pipettes, test tubes, and glass-ware, which can be bought from time to time, so inexpensively that their cost is not noticed. This will enable the girl to do the more common examinations such as blood sugars, N. P. N.'s, or practically anything that would be needed immediately. In a small laboratory it is best to buy prepared solutions as needed and not make up large amounts which might deteriorate. This part of the laboratory is of value especially in those cases where Sulfonamides are used because the determination of the blood level of the drug is a matter of major importance.

* Deceased August 18, 1944.

The routine blood count and Sahli are simple, cost only for the time used, and give an intimate personal knowledge of the case which reports from the hospital do not. You may get a report on a stained specimen of macrocytosis or poikilocytosis, but when you look at a slide *you know* just how serious it is. Also, this routine blood work can be used with benefit to doctor and patient both on indigent patients, or those who could not take the extra time to go to a laboratory even if convenient.

A differential white count may be of great value in many cases where the diagnosis would otherwise be questionable—mononucleosis, for example. Bone marrow slides are very instructive and interesting, but should be left to the specialist; as also the blood cultures and bacteriological work, which requires high technical skill and much time.

You notice I say "the girl" can do these tests. It is my belief that every doctor should have some arrangement whereby these examinations can be done for him at the time of consultation, when they will be of the most value to him, and to the patient. I know at times a doctor is so rushed that unless their indications are so obvious that it would be frank negligence to skip them, they are not done. Disease, in it's early stage, can be most readily cured at a time when it may be most difficult to diagnose clinically.

The total equipment should be gauged by the efficiency of the help available, the knowledge of the doctor as to the value of the tests, the desirability of them in his particular type of work, his location (this may be affected by the difficulty of contacting a really reliable laboratory), and the time that can be spared for such work.

Many physicians greatly appreciate the help given by an electrocardiograph in the diagnosis of cardiac arrythmias and coronary accidents, and the girl can be sent out, if needed to take these satisfactorily.

Basal metabolism may fit in with some practices, but the majority of cases requiring this test can be better referred to the hospital. Some outfits have a vital capacity arrangement which is of much more value than is realized generally. A water spirometer, which is considered the most reliable, can be bought separately.

These, together with more advanced and not as commonly used articles such as blood typing serums, cross-matching tubes, dried plasma, with sterile intravenous and hypodermoclysis sets, saline, glucose, etc., oxygen tanks for cardiac emergencies or intravenous anæsthesias, a folding cot for the EKG's and basal metabolisms, can all be very easily arranged in a room six by fifteen feet, leaving plenty of room to work. Apparatus which is not going to be used *regularly* has *no* place in an office laboratory. They tend to make one neglect the ordinary useful tests.

Summary

1. A laboratory is now considered of major importance in the practice of medicine.

2. It need not be expensive or elaborate to be of very real benefit in diagnosis and treatment.

3. A laboratory should be developed along lines needed and used by that particular doctor in his daily work.

4. The work can be satisfactorily done by any intelligent high-school girl who has been taught first by the doctor, with later some courses at graduate training centers for more advanced procedures.

5. It is well not to forget that, while laboratory aids are important, nothing can take the place of a complete history and a good physical examination.

The control of tuberculosis in the army must be given serious thought. Elimination of the potentially tuberculous recruit by X-ray examination at the time of induction into the army is not enough. Continued systematic prevention of tuberculosis in the army is the real task to be faced.—Edgar Mayer, M. D., *Modern Medicine,* December, 1940.

The job of eradicating tuberculosis is no longer one for the shotgun but for the more selective rifle.—Louis I. Dublin, *Amer. Rev. of Tuber.,* Feb., 1941.

Editorial

Vocational Rehabilitation

The advent of returning veterans, large numbers of them in urgent need of medical attention and care in many forms, has turned the home-front spotlight on the State Board for Vocational Education, an agency founded by the Maine Legislature in 1921.

Medical men throughout the State have taken unusual interest in the aims and accomplishments of the State Board because much of its endeavor fits into the general pattern of trying to keep all men strong and healthy.

Federal legislation in the form of the Barden-LaFollette Act of 1943 contributes no end toward the challenging spectacle of attempting to rehabilitate the physically handicapped.

Behind the creation of the State Board for Vocational Education was the theory that it was better for the State to train its handicapped citizens for vocations into which they might fit rather than to allow them to be recipients of public or private charity.

To this end the State Board has established numerous sub-agencies including guidance and counsel; school training; employment training; correspondence courses and tutorial instruction; artificial appliances; medical examination; and placement.

In no wise is the rehabilitation service a placement agency, although whenever possible it assumes responsibility for finding satisfactory employment for disabled persons trained under its supervision.

The State program is being worked hand-in-hand with the Barden-LaFollette Act. Under provisions of the Federal legislation service men who receive disability discharges, as the result of non-service connected handicaps, are eligible for civilian rehabilitation service. The amended act goes so far as to provide for surgery and therapeutic treatment to remove or reduce relatively simple physical handicap.

The Physician and the Control of Gonorrhea in the Armed Forces—Continued from page 210

that occasionally the diagnosis may be in error. That errors in diagnosis will occur is conceded. They do and will occur with respect to the diagnosis of all the diseases of man, but this does not prevent the physician from continuing to make the diagnosis and treat the patient accordingly. Every practicing physician has, at one time or another, diagnosed and treated measles, for example, where it did not exist. This has not resulted in his refusal to make the diagnosis of measles ever after. We have committed and shall continue to commit errors. We can only hope that they will be few. We must not forget that errors of omission can be as disastrous for the health of the patient as those of commission.

In the clinical diagnosis of gonorrhea one particular type of case deserves special mention. It involves the female who seeks medical advice because she has been named as a contact to a case of gonorrhea. If the contact history is substantiated treatment for gonorrhea should be instituted even in the absence of clinical findings or laboratory confirmation. The dangers inherent in treatment are slight, while serious complications might result from failure to treat.

The efficacy of our treatment for gonorrhea has improved immeasurably within the past decade. Modern treatment of uncomplicated gonorrhea consists of the administration of sulfathiazole or sulfadiazine, one gram, four times a day for five days, and no local therapy. This treatment régime will cure from one-third to two-thirds of the cases of gonorrhea and without untoward effects. Cases which are not cured by the sulfonamides usually can be cured very rapidly with penicillin.

A plea is made to practicing physicians to liberalize the diagnosis of gonorrhea, especially among female contacts of members of the armed forces and to treat cases on the basis of history and clinical findings. The control of venereal diseases is vital to the war effort. The practicing physician is in a strategic position to be of immeasurable service in combatting this problem.

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County News and Notes

Knox

Paul A. Millington, M. D., of Camden, has been elected Secretary-Treasurer of the Knox County Medical Society to succeed Abbott J. Fuller, M. D., who died recently.

At a meeting of the Society held October 10th, 1944, Freeman F. Brown, Jr., M. D., and Oram R. Lawry, Jr., M. D., both of Rockland, were elected to membership. Drs. Brown and Lawry are in Military Service.

Penobscot

The Penobscot County Medical Association held its regular monthly meeting on Tuesday, October 17th, starting with a dinner at the Bangor House, Bangor, at 6.30 P. M.

During the meeting reports were given by delegates to the Maine Medical Association's annual meeting in June. A committee was appointed to bring in a resolution on the death of Dr. Charles H. Burgess. A committee was appointed to bring in nominations at the next meeting for officers for the ensuing year.

The meeting was held in conjunction with the members of the Armed Forces as one of the post graduate war time series. The speaker was Edwin H. Place, M. D., Chief of the South Department of the Boston City Hospital. The subject was *Contagious Diseases and Complications.* The talk was illustrated by Kodachrome slides of skin manifestations of infectious diseases.

The attendance was 37.

FORREST B. AMES, M. D.,
Secretary.

Piscataquis

The Annual Meeting of the Piscataquis County Medical Society was held September 21, 1944, at the office of E. D. Merrill, M. D., Dover-Foxcroft, Maine. The meeting was called to order by the President, A. M. Carde, M. D. Minutes of the previous meeting were read and approved.

It was voted to continue the Officers who are now holding office in the Society for another year, namely:

President, Albert M. Carde, M. D., Milo.

Vice President, Ralph C. Stuart, M. D., Guilford.

Secretary-Treasurer, Harvey C. Bundy, M. D., Milo.

HARVEY C. BUNDY, M. D.,
Secretary.

York

The regular quarterly meeting of the York County Medical Society was held in Kittery, Maine, Wednesday, October 11, 1944.

Dinner at Warren Wurm's Restaurant, at 1.00 P. M., was followed by the meeting at the American Legion Hall at 2.00 P. M.

Ralf Martin, M. D., of Portland, gave a very interesting talk on *Recent Advances in Rheumatic Fever* which was followed by a discussion of the subject.

R. V. N. Bliss, M. D., of Blue Hill, President of the Maine Medical Association, gave a fine talk on State Association matters.

Adam P. Leighton, M. D., of Portland, President-elect of the Maine Medical Association, spoke relative to opening a Medical School in Maine.

Frederick R. Carter, M. D., of Portland, Secretary-Treasurer of the State Association, and seven medical officers from the U. S. Navy Yard were also guests at the meeting.

C. W. Kinghorn, M. D.,
Secretary.

New Members In Military Service

Knox

Freeman F. Brown, Jr., M. D., Rockland.
Oram R. Lawry, Jr., M. D., Rockland.

Necrologies

Mortimer Warren, M. D., 1873-1944

Mortimer Warren died suddenly at his home at Cape Elizabeth, Maine, on October 8, 1944. His place among his colleagues will be hard to fill. He spent a full and resultant life as a clinical pathologist, bringing to the practice of his profession scientific ardor and a great love of his fellow men.

Doctor Warren was born on December 17, 1873, at Cumberland Mills, Maine, the son of John and Harriet Brown Warren. His family was then and still are associated with the S. D. Warren Paper Mills in that town, where he went to grade school. He went also to Westbrook High School, Philips Andover Academy, was graduated from Bowdoin College in 1896, and entering Johns Hopkins took his medical degree there in 1900. After graduation he studied in Germany during 1902. As assistant clinical pathologist, he began his medical career at Cornell Medical School in New York City from 1902 to 1910, and served as pathologist at Roosevelt Hospital from 1910 to 1916.

In June, 1917, he was commissioned in the Medical Corps of the United States Army and served at Fort Benjamin Harrison and Fort Pike in this country. In November, 1918, he went abroad with Base Hospital 100 to be stationed at Savenay, France, where in March, 1919, he was made chief of the medical services, and then commanding officer of the Unit. Returning to this country in August, 1919, he was honorably discharged as a Lieut. Colonel in the Medical Reserve, United States Army.

In 1920, Doctor Warren decided to return with his family to the State of Maine. Coming to Portland to practice he became pathologist at the Children's Hospital, and in 1922 began his work at the pathological laboratory of the Maine General Hospital. In November, 1932, he took full charge of the Hospital's new pathological laboratory.

To the development and extension of this laboratory he gave his full time and his creative talents for the rest of his life. Its usefulness spread far beyond the Portland area and his constant struggle to perfect its services and to diffuse the pathological knowledge is perhaps his greatest contribution to medicine in Maine. The laboratory grew as the hospital expanded and as war enlarged its services, many young men and women began their laboratory careers under Doctor Warren's direction and went on to responsible positions. Over the years he acquired a valuable and complete library of medical literature always at the disposal of his colleagues.

Doctor Warren foresaw the need of medical preparation to the present war. Active in the Civilian Defense preparations he worked to prepare a blood bank in the hospital to be available for any civilian emergency. This was in addition to his participation in the success of the Red Cross blood bank for the Armed Forces.

In recent years, Doctor Warren put his energies and solicitudes into the creation of a tumor clinic at the Maine General Hospital. This clinic makes available to cancer patients all the medical services united for diagnosis, prevention and care. Likewise he took an active part in the Women's Field Army for the Study and Control of cancer. Unfailingly he braced with knowledge and faith all efforts to widen the benefits of medical truths. He was Chairman of the Cancer Committee of Maine Medical Association since the establishment of the Committee.

In Maine, Doctor Warren headed the Infantile Paralysis Commission during 1929 and 1930, created by Governor Tudor Gardiner to study and control the disease in Maine, and through his many medical connections he was in close touch with all research in this field. He worked all his life to widen the horizons of medicine to alleviate for more and more people the affliction of disease.

In 1931, Bowdoin College made him an honorary Doctor of Science on the 35th anniversary of his graduation. He was an active member in the Committee of Physicians, that group of 300 medical men whose promotion of modern medical practice centered in the School of Medicine at Yale University under the leadership of Doctor John P. Peters. Doctor Warren was also a member of the Cumberland County Medical Society, Innominate Club, Portland Medical Club, American Medical Association, the New England Pathological Association, the New England Cancer Society, the American Society of Clinical Pathologists, the Society for the Study of Internal Secretions. He was a life member of the American College of Physicians and a Diplomate of the American Board of Pathology. His scientific achievements were recognized by publication of his biography in the Directory of American Men of Science. He was an honorary member of Rotary International.

In 1906, he married Mary Pendexter of Bath, Maine, who died in 1911, at the birth of their son John P., who is now a corporal in the Army Air Forces, at Hobbs, New Mexico. He married Pascia Personya of Hartford, Connecticut, in 1914, who survives him. A son of this marriage, Lieut. M. P. Warren is also in the Army Air Forces, stationed at Walker Field, Victoria, Kansas.

Abbott James Fuller, M. D., 1885-1944

Abbott James Fuller, M. D., 59, of Pemaquid, Maine, died suddenly August 18, 1944.

Doctor Fuller was born at Shoreham, Vermont, February 28, 1885, son of James Kenney and Maria Elizabeth Green Fuller. He was a graduate of Rutland (Vermont) High School, of Newton Academy, and received his medical degree from the University of Vermont College of Medicine in 1907. He practiced medicine in Warren, Vermont, from 1907 to 1911, in Swans Island, Maine, from 1911 to 1925, and in Pemaquid from 1925 to the time of his death. He was a member of the staffs of the Knox County General Hospital in Rockland, and the Miles Memorial Hospital in Damariscotta. He served as an Officer in the U. S. Army during World War I.

Doctor Fuller was a member of the Knox County Medical Society, the Maine Medical Association, and the American Medical Association. He was Secretary-Treasurer of the Knox County Society, and was appointed a member of the Scientific Committee of the Maine Medical Association at the 1944 annual meeting.

He is survived by his widow.

RESOLUTION

WHEREAS, the Knox County Medical Society has lost a true friend and esteemed associate in the passing of Doctor Abbott J. Fuller,

It is resolved: That it be recorded in the records of the Society of the high esteem in which Doctor Fuller was held by his associates in the medical profession not only for his interest and energy in our endeavors, but for his general high character as a practitioner and as a man. And further, that a copy of this Resolve be sent by the Society to the widow of our dear friend.

John A. McDonald, M. D., 1866-1944

John A. McDonald, M. D., 78, practicing physician at East Machias, Maine, for fifty-six years, died in Calais Hospital, Calais, Maine, Tuesday, October 10, 1944.

Doctor McDonald was born at Machias, Maine, August 28, 1866, son of the late Donald and Eliza Calligan McDonald. He was graduated from Machias High School and received his medical degree from Jefferson Medical College, Philadelphia, in 1886.

He was a member of the Washington County Medical Society, the Maine Medical Association, and the American Medical Association. In 1936, he received the Maine Medical Association's gold medal in recognition of fifty years in the practice of medicine. He retired two years ago. Twice he represented the Maine Medical Association as delegate to the American Medical Association.

He was Washington County Medical examiner for 16 years, health officer in the Machias area for five years, and had served as superintendent of schools at East Machias.

Doctor McDonald served two terms in the State of Maine House of Representatives, 1923-1925, and two terms in the Senate, 1933-1935.

Surviving are three daughters, Mrs. Sarah Grant, Miss Adelaide McDonald, and Miss Lillian McDonald; a step-daughter, Mrs. Josephine Denison; a step-son, Clayton Drew, and a brother, James A. McDonald, and six grandchildren.

Book Reviews

"Medical Diagnosis"

By: Roscoe L. Pullen, A. B., M. D., instructor in medicine, Tulane University of Louisiana School of Medicine; assistant clinical director, Charity Hospital of Louisiana at New Orleans; formerly Fellow in clinical endocrinology, Duke University School of Medicine and Duke Hospital, Durham, North Carolina.

With a foreword by John H. Musser, B. S., M. D., F. A. C. P., professor of Medicine, Tulane University of Louisiana School of Medicine; senior visiting physician, Charity Hospital of Louisiana.

With 584 illustrations and 12 colored plates.

Published by W. B. Saunders Company, Philadelphia and London. Price, $10.00.

Activated by a desire to fill what he believes to be an urgent and apparent need for an advanced book on medical diagnosis covering the entire body, rather than any one part, Dr. Pullen comes forward with this enlightening edition which embodies all of the sweeping changes in the field of diagnostic undertakings.

Mindful that the market already is covered by publications on diagnostics, Dr. Pullen sets out to justify his efforts (although such justification appears not necessary) in the explanation that the examination of the patient has undergone marked changes in recent years. His text outlines in detail the changes and reasons for them.

In his foreword, Dr. Pullen says, "No longer is the subject considered apart from the disease; its direct relationship to altered body states, whether physiologic or anatomic, must be understood."

The Tulane professor inculcates in his publication chapters prepared by nearly three score medi-

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Proceedings

NINETY-FIRST ANNUAL SESSION

Maine Medical Association

ROCKLAND, MAINE

JUNE 25, 26, 27, 1944

First Meeting, House of Delegates Continued from the October Issue of the Journal, Page 199

DR. PLUMMER: I move that the Society not go on record as favoring obtaining an Enabling Act, or of incorporating in any way under general law, as an insurance company.

DR. SWETT: I will second that motion.

DR. FOSTER: Some men didn't understand clearly the import of Dr. Plummer's motion.

CHAIRMAN BLISS: Dr. Plummer makes the motion that the Medical Association refrain from going on record as applying for any Enabling Act, to conduct an insurance business, from the Legislature.

DR. FOSTER: Does that change the attitude of the Society so that it could never go to the Legislature and ask for an Enabling Act?

DR. RICHARDSON: I move that this matter be left on the table, for the Councilors to act upon with their powers during the ensuing year, if they see fit to do so.

DR. LEIGHTON: There is a motion before the house before that can be entertained. Am I allowed to speak, as a trespasser and interloper here? This subject is very, very important. I believe that we certainly should become panicky and jittery about it. Some of you in this room, you will recollect, will remember the date when we sold out, lock, stock and barrel, to this crowd of osteopaths. Here, we are considering a question of a similar nature. The very presence of these pseudo-medical practitioners in the proposition, vitiates the atmosphere, as far as I am concerned.

I am absolutely opposed to the proposition. Tomorrow I have the pleasure of presenting a paper alluding to this subject. I hope that you will vote against this thing; give it consideration and then vote against it again, and remember that old adage still holds good.

CHAIRMAN BLISS: Dr. Plummer has made a motion that we refrain from seeking an enabling Act by the Maine Legislature, allowing us to operate a plan for prepaid medical care. It has been seconded. Remember, if this motion is put through you deprive yourselves and those coming back from service across from taking advantage of something which the future may actually demand. If you are in doubt now that there is a popular demand for such a thing, you can conceive that in the future such a demand may exist. Do you wish to pass this motion, which has been made and seconded.

All those who are in favor of Dr. Plummer's motion will please raise their right hands. Those opposed?

There are two votes for the motion and the majority are opposed to it; therefore, the motion is lost.

DR. RICHARDSON: My motion was that this matter be laid on the table.

DR. LEROY SMITH: I will second that motion.

DR. FOSTER: A point of information. The Committee appointed to make a survey of medical and hospital care still operates, as I understand it, and it was not discharged. Would it be out of order to refer that question to that Committee for a report? Could it be taken from the table and referred to that organization?

CHAIRMAN BLISS: If they would consider postponing it.

DR. FOSTER: Perhaps they would clarify the situation and bring in a different recommendation.

CHAIRMAN BLISS: Of course, this matter was brought up today after a year of struggle with this question, in the hope that some decision might be made. However, the motion has been made and seconded.

DR. STUART: That means it won't be passed on again for another year.

CHAIRMAN BLISS: Not by this House of Delegates.

DR. STUART: We have a delegate from one of our large counties who has signified his desire that this situation should be clarified. I think that we owe it to him to give it a little bit of discussion before we throw it aside.

CHAIRMAN BLISS: This matter is open for discussion.

DR. STUART: We are all accepting fees from industrial accident insurance companies, who are also paying the osteopaths. In our particular district, we do a lot of industrial accident work and they pay approximately two-thirds of what is our usual, regular fee. They have no objection if we charge the patient extra. I can't see any particular difference between accepting insurance moneys from industrial accidents over any other type of sickness that I know of and that may occur. There may be something involved here that is wide open.

CHAIRMAN BLISS: The question involved is in the condition under which you operate. In your commercial insurance companies, you are not a part and partner of the contract in which the osteopaths operate, also.

DR. LEROY SMITH: I seconded this gentleman's motion, with the hope that this would be placed on the table, perhaps indefinitely, but I opposed Dr. Plummer's motion for the reason that I felt that if I voted for that, it might tie the hands of the officers of this Association at some very indefinite future time.

I feel that it should be placed on the table indefinitely, but that the officers of this Association should not be tied up, or the Association should not be tied up, so that some legality would have to be gone through before something else should be attempted.

DR. PLUMMER: If I understand Parliamentary procedure, if this vote to lay on the table is carried, then the matter may be brought up and renewed tomorrow by somebody voting to reconsider, and then the thing is practically where we started. Am I right?

CHAIRMAN BLISS: Yes.

DR. LEROY SMITH: I want, personally, to express my appreciation, and I think all of the members of the Association do, to the Council for the work it has necessarily done on this matter during the past year. I want to thank them for all that work that they have done. But I hope this will be put on the table for many years.

Dr. Foster: May I add a word to what Dr. Smith has already said, and may I review the history a little bit.

In 1940, the Committee was appointed to survey the situation. That was four years ago, and the members of this Association say they do not understand the proposition at the present time. Now, I think it is important to understand it. It is probably a simple way, to put it on the table and forget it. But I assure you the people are not going to forget it and it isn't going to be, in my opinion, to the credit of the members of the Maine Medical Association to have the press release the fact that the members of the Maine Medical Association have indefinitely postponed any consideration of prepayment of medical care.

There must be a way for prepayment of medical care. Many plans fail. It seems to me that the Maine Medical Association ought to be able to work out a plan which will be a help to the people who need medical care, and there are people who need it. There must be some way to do it. It seems to me—well, I don't know the word to use, but it is an indefinite attitude to take, to say the least. If the motion to table this matter is passed, I hope it will be lifted from the table at an early date and carefully reviewed as a specific plan.

Dr. Carswell: It seems to me that the Council has done a great deal of work on this and, as you say, they have spent a year considering this particular plan. As I understand it, there is a particular plan being offered today for the settlement of this matter. That plan is and has been explained. Now, before this House carries through any question of tabling the matter, I think that we should remember that if we reject this plan and reject it properly by a properly made motion, that doesn't necessarily mean that we have no other opportunity of bringing up, between now and the next meeting, a substitute plan or any other plan. It seems to me more reasonable not to throw the thing on the table and forget it for an indefinite period of time, but rather to leave an opening for ourselves between now and tomorrow to present another plan.

Dr. Leroy Smith: We don't need any plan, in my opinion. The more plans, the more we are going to find ourselves in the cauldron. I see no reason why any man should not enter into a contract with the Employers', the Commercial Casualty, the Travelers' Insurance, or anyone else to take care of their employees, if necessary; but, I can't yet see how I have to take the responsibility of John Public on my shoulders as to how he pays his bills. I think that is up to the public.

Dr. Laughlin: There is one thing that has not been touched upon here today. I travel around the state a good deal. I see a very crying need for it. All communities don't follow up what I am going to say, but some do. Some communities I go into—say there are four medical men, and two are going away and there are two there on the job. The public can get them in the day time and in the evening. And there are other places I go to where four or five medical men of the town are all away; some are out fishing, and some have taken the week-end off, and the business of those men is going right over to the osteopaths. They are sitting on the side lines, waiting for it. Now, the physicians in every community should get together on this matter. Dr. Stevens told me of a case on the train the other night of a man who had a duodenal perforated ulcer, and he tried nine doctors, and not one of them could be reached. Finally, Dr. Stevens picked him up at 11 o'clock and got him fixed up at four the next morning.

Now, I think that we had better begin, among ourselves and in the medical societies, to do something to cover the public. If we don't, we are going to hear more about it.

Dr. Frederick T. Hill, Waterville: May I have the privilege, as an old-timer, to say something here. I feel somewhat on the defensive because I framed two motions that the special committee passed and with which, subsequently, I went to the Council.

I agree with Dr. Piper. The first motion was that we felt that some prepayment health plan would be in the best interests of the people of Maine. That is one thing that I think ought to be settled. If that is not so, then we can drop the whole thing. That would settle the matter.

I don't think that we ought to get into a consideration of any specific bill now. But, there is a reason for some one to explain it. Times have changed greatly and the practice of medicine has changed, too. We are in a changing age. I agree with Dr. Foster that it might be a detrimental thing for this Association to go on record as saying that we are opposed to any such plan. When enough people want something badly enough, they are going to get it.

It was suggested that most of our people will be taken care of. Well, I want to present a specific case of a young college instructor, whose salary is no more than in ordinary times, and who was completely knocked off his feet by an obstetrical fee of $400.00 or $500.00. Well, had he been able to prepare for his medical care, I think he would be differently inclined towards the profession.

We have all seen what the Blue Cross has given to people demanding hospitalization. I think we should be open-minded about the question of prepayment medical health plans.

I am not entirely in favor of this plan.

Now, my second motion was that we advise entering into such a plan with the Blue Cross, providing the proper standards of medical practice were adhered to, which meant, of course, eliminating the unregistered practitioners. If that is impossible, I don't favor it at all.

I would hate to see the Association close the doors indefinitely to anything which may be progressive, however.

Chairman Bliss: You have heard the discussion, and there is a motion before the House.

Dr. Leroy Smith: Mr. Chairman, may I ask what is the consensus of the reports as either for or against this matter?

Chairman Bliss: There is no definite division, Dr. Smith, between the No vote and the Yes vote, because there are several that are uninstructed. Now, what will you do with this motion to lay on the table?

A Member: Will Dr. Richardson please restate his motion?

Dr. Richardson: I move that this matter be laid on the table, with the provision that the President and the Council whom we can trust and the Committee that represents the plan can bring it up before the County Societies any time they so wish, and if they want to postpone it another year, all right. I don't think that we ought to bury it, but we certainly cannot accept it now. The young man coming back from the service later on should have a chance to vote on this matter.

Chairman Bliss: Gentlemen, you have heard the motion which was previously seconded. Will all those in favor of the motion please raise their right hands? Those opposed?

Sixteen hands were raised favoring the motion, and two hands were raised in opposition to the motion, and the motion was carried.

Chairman Bliss: The motion is carried.

Now, I am going to ask you to vote on one more question concerning this matter. Will someone make

a motion, or will you vote on whether you are in favor of a plan for prepaid medical care?

Dr. Carswell: I move that the House of Delegates go on record as being in favor of the consideration of some prepaid medical plan.

This motion was duly seconded, and was carried, with two dissenting votes.

Chairman Bliss: We have another important item of business, Gentlemen, so please be seated. This is the House of Delegates in which your business is transacted. Whether it takes one hour or six, we must transact this business.

I have here a letter from Dr. Roscoe L. Mitchell, a member of the Social Hygiene Committee, to Dr. Carter, Secretary of the Maine Medical Association, which I am going to read to you.

SOCIAL HYGIENE REPORT

To the Officers and Members of the Maine Medical Association:

As a member of your Social Hygiene Committee, I am aware of certain differences of opinion, not only among members of the Association, but also within the present Social Hygiene Committee, regarding the so-called venereal disease control law, Chapter 358 of the Public Laws of 1943, and also concerning the program proposed by the State Department of Health and Welfare, designed to function with the coöperative participation of the medical profession and the State Bureau of Health.

I am also familiar with some of the difficulties encountered by the State Bureau in implementing a program under this law which will meet with the approval of the medical profession generally, and at the same time, accomplish a reasonable degree of control of the venereal diseases, which appear to constitute one of our major public health problems. Various agencies are actively interested in this problem, the Army, Navy, the U. S. Public Health Service and various organizations within the state, particularly the Social Protection Committee set up under the Office of Civilian Defense.

The United States Public Health Service is financially involved to the extent that it contributes to the state approximately $50,000 annually to be expended in carrying out an approved program of venereal disease control. The principles and objectives of such an approved program, as issued by the Public Health Service, as well as the present state law, have been given consideration in formulating the proposed program, which is receiving more or less critical attention.

In formulating this program, the Bureau of Health has sought on at least two meetings since September, 1943, the advice and council of the other members of your Committee, but on neither occasion have those members been present. Thus, the Bureau has not had the advantage of the Committee's advice in setting up the details of the program outlined in a former report of this Committee, and published in the Journal of September, last year.

In view of the state-wide and nation-wide interest in the venereal disease problem and its importance to the efficiency of our armed forces, as well as the civilian population, it would appear to be important that this Association take such action as it deems proper to bring about coördination of effort and team work of all personnel concerned with venereal disease control activities, including state, community and professional people.

It is evident that the entire burden of formulating a program to bring about such coördination and team work, should not rest solely with the Bureau of Health or any one of the agencies participating in a problem involving state-wide public concern.

It is evident also that the Bureau of Health, in carrying out its responsibilities under the state laws, cannot contact the entire professional personnel of the state individually, but needs the advice and council of representative members of the profession who can, without prejudice, represent the Association, and who can afford the small amount of time necessary for such service.

I respectfully suggest that in conformity with the usual procedures of this Association, such a Committee be designated, none of the members of which are in the official agency, and instructed to represent the Association in taking such steps as may be necessary, in coöperation with interested agencies, to secure a workable program for venereal disease control; such as, program planning, satisfactory legislation, etc.

Respectfully submitted,
Roscoe L. Mitchell, M. D.,
Member Social Hygiene Committee,
Director of Health.

Augusta, Me., June 23, 1944.

Chairman Bliss: You have heard Dr. Mitchell's letter and his minority report. The Chair awaits a motion regarding this letter.

Dr. Swett: May I ask if the Chairman will summarize that letter? It is rather lengthy, and I know that most of us didn't grasp the contents fully.

Chairman Bliss: Dr. Mitchell, would you please do that for us?

Dr. Roscoe L. Mitchell, Augusta: This constitutes, as I have said, one of our main and our major health problems. Actually, in the State of Maine, we have the instance of venereal disease higher than any of the New England states. The purpose of this letter is to bring to the attention of the Delegates of this Association that it is a problem and that the State Bureau of Health would like the assistance of the medical association in solving this problem. As I have said here, we cannot do it alone, but we believe that some method could be worked out which the medical profession will be willing to participate in for the control of these diseases.

This report is simply to ask the delegates to give consideration to that problem and offer some solution.

Chairman Bliss: Dr. Mitchell has stated his desire.

This closes the business of this meeting. I wish to call to your attention that the election of Councilors for the Third and Fourth Districts will take place at tomorrow's meeting of the House of Delegates, and there will also be the election of the President-Elect.

(Whereupon, the First Meeting of the House of Delegates was adjourned at seven-thirty o'clock in the evening.)

HOUSE OF DELEGATES
SECOND MEETING — JUNE 26, 1944

The second meeting of the House of Delegates of the Maine Medical Association was held on Monday afternoon, June 26, 1944, at the Sam O set Hotel, Rockland, with President-Elect Bliss presiding.

The roll call was made by the Secretary and twenty-three delegates responded. (Ten delegates constitute a quorum.)

Chairman Bliss: Our first order of business will be a report from the Chairman of the Nominating Committee, Dr. Harold Jameson. (Dr. Jameson then read the report of the Nominating Committee as published in the July, 1944, issue of the Journal, page 143.)

Chairman Bliss: Gentlemen, you have heard the report of the Nominating Committee. What is your pleasure?

Dr. Plummer: I move that we accept the report as read by Dr. Jameson, and I ask the unanimous consent that the Secretary cast one ballot for those names as read.

This motion was duly seconded and was carried.

Our next order of business is the election of a delegate to the American Medical Association for the next two years. The Chair awaits your nominations.

Dr. Jameson: I should like to nominate Dr. Thomas A. Foster of Portland.

This motion was duly seconded and was carried.

Chairman Bliss: Our next order of business is the election of a Councilor from the Third District and also from the Fourth District.

Dr. Carswell: I should like to nominate Dr. C. Harold Jameson, of Rockland, as Councilor from the Third District.

This motion was duly seconded and was carried.

Chairman Bliss: I now await nominations for Councilor for the Fourth District.

A Member: I wish to nominate Dr. John O. Piper, of Waterville, as Councilor from the Fourth District.

This motion was duly seconded and was carried.

Chairman Bliss: Under the heading of unfinished business, there is the matter of Dr. Mitchell's letter, which was read at the end of the first House of Delegates' meeting; this letter had to do with the former functions of the Committee on Social Hygiene. There has been some dissatisfaction on the part of the United States Public Health Service with Maine's Venereal disease record. That we are responsible for that condition is not implied, but that our aid is sought to help remedy it is certain.

Now, on the statutes of the State of Maine, there exists a law, a very adequate law with teeth in it. In that law, there is a provision to the effect that clinic patients, poor people, presumably, are to be reported to the State Board of Health by name, and that private patients can be reported by number. It has been charged in the past that this is class legislation at its worst, and there are those who desire that this law be altered so that all classes of society may fare alike. There are certain objections to reporting by name. Indiscreet social workers and district nurses constitute one of the objections. The accessibility of records in the future constitute another objection. I am summarizing these objections, in order to save time.

The question is now open for discussion.

Dr. Johnson: Mr. President and members of the House of Delegates. As you will all remember, last year this matter was taken up concerning this very one thing that we object to, and that is the name and address of the clinic patients.

In Portland, for instance, where we have a very large clinic, believe it or not but there are very many respectable individuals who, unfortunately, have acquired this disease and have to go to the clinic in order to get their treatments.

Now, we feel that it is unfair and discriminating and very undemocratic, and therefore, as members of the House of Delegates, we should like to amend that so that it reads that nobody shall be reported by name and address unless it is the desire of the physician. I realize that we only have very little time left, so I am going to stop at the present time, and I wish some other delegates, would say something concerning this law.

Dr. Stuart: This is, indeed, a discriminatory law. A man with $10,000 can keep his troubles to himself, and the man with ten cents cannot.

I believe that we should take steps to try to have the law abolished, because the old system of numbers, and the names of the patients in the doctor's office is just as effective as any new type of law. We cannot control the patients. I cannot see how the control can be any better by giving the names of the individuals to the State for all hands to look at.

I move that we take steps to try to have this law abolished.

Dr. MacDonald: I heartily agree with Dr. Johnson, that the innocent should not suffer; the law should be changed in order to make the situation fair all around.

Dr. Jameson: I cannot see any reason for discriminating between the clinic patient and the private patients. It might be necessary, eventually, to know the name; I suppose that will eventually become available. I can see no reason for discriminating between the two types of patients, and I would be in favor of making an effort to eliminate that distinction.

Dr. Porter: I should like to know more about why the two classes were originally discriminated against. I wonder if there is anybody here who could tell us. As I understand it, there was a bill put forth which would have all classes reported by name, and I don't know at whose suggestion it was, but at some one's suggestion it was changed to include only the indigent, so to speak.

Dr. Swett: Mr. Chairman, I wonder if it might not be well to have the law reviewed at this House of Delegates' meeting, to get a fair interpretation of the question, and if I am not presuming too much, would it be in order to ask the Acting Director, of the State of Maine Division of Venereal Disease Control, Dr. McCloskey, to give the other side of the picture? (Dr. McCloskey's remarks and the discussion preceding the following motion is on file in the Maine Medical Association office.)

Chairman Bliss: Now, in a very few minutes, we can settle this matter of whether or not this Association wishes to go on record as favoring an amendment of this law so that it will read that all persons, all cases of venereal disease, shall be reported by name or number, at the discretion of the reporting physician. That is a very small amendment to the law, and that

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cal men which allows for coverage of nearly every type of examination.

The interne, young physician just starting out or the tested veteran will find much of gainful reading in Dr. Pullen's works.

"Advances in Internal Medicine"

Edited by: J. Murray Steele, M. D., Welfare Hospital, New York University Division, Welfare Island, N. Y., with assistance of seven associate editors.

Published by Interscience Publishers, Inc., New York. Price, $4.50.

Here is the first volume of an endeavor by a group of medical men from widespread ends of the universe to condense into a single publication reports on progress made in numerous fields of medicine.

Editor Steele and his seven associates hold enviable reputations among medical men, and their discussions which fill this initial volume are based on known progress in the treatment of a large number of diseases.

Among topics discussed are the use of the Miller-Abbott tube in the diagnosis and treatment of disorders of the gastro-intestinal tract; use of insulin in diabetes; infections of the urinary tract; trends in the study of epidemic influenza; and hypertension.

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is all this whole question is about. Will some one make a motion to that effect?

DR. KINGHORN: I move that this House of Delegates go on record as desiring to have the law amended.

DR. JOHNSON: I will second that motion.

CHAIRMAN BLISS: It has been moved and seconded that this House of Delegates go on record as desiring an amendment, an alteration, in the present venereal disease law, so as to read that all cases of venereal disease shall be reported by name or number, according to the discretion of the physician reporting. All those in favor of that motion will please signify by saying "aye." Those opposed?

There was a chorus of "ayes" and the motion was carried, unanimously.

CHAIRMAN BLISS: We shall now have a report from the Financial Advisory Committee, by Dr. Pratt.

DR. PRATT: We are in the black, instead of being in the red. We have had no meetings until today. That is all there is to report.

DR. PLUMMER: I would like to inquire to what extent the Financial Committee has recommended to the Council in the past two years that it should invest a considerable part of the funds of the Association in government bonds?

SECRETARY CARTER: As long as we are in the black, we have made application for $4,000 worth of bonds at the present time, and they will be here shortly.

CHAIRMAN BLISS: We have with us a representative of the Farm Security Administration, Dr. Charles L. Newbury, Regional Medical Officer, but we do not have enough members left to give us a skeleton group here, so that we shall have to meet later to discuss the Farm Security matter.

We shall now adjourn this meeting, subject to call at a later time.

(Whereupon an adjournment was taken at 7:20 o'clock in the evening.)

(To be continued in the December issue)

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The Health Hazards of Welding Fumes ***

By Walter E. Fleischer, Lieutenant Commander, MC-V(G), USNR, Assistant Chief Health Consultant, U. S. Maritime Commission

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WELDING FUSES

During the present war, welding has emerged from comparative obscurity to perhaps the most important single craft in the construction of ships. A tremendous number of inexperienced workers were engaged to work at this relatively new occupation. Naturally some complaints arose of health hazards allegedly due to welding fumes. During the present war, the average physician has been severely limited in his time and unfortunately has little leisure in which to inspect shipyard construction operations or to confer with shipyard Medical Departments. This article is offered with the purpose of presenting a brief account of welding processes, of the composition of welding electrodes, of the health effects of welding fume components and of the ventilation required for welding.

In this connection the paper of Cranch and Vosburgh[1] contains an excellent, non-technical summary of the subject and that of Britton and Walsh[2] a comprehensive review of the literature. We have drawn freely from the paper of Drinker and Nelson[3] in the preparation of this article.

All modern welding processes are designed for the rapid production of intense heat within a small area. The process in greatest use today for steel fabrication and in production welding is the electric arc employing coated welding electrodes. Gradually the coated electrodes have displaced the uncoated, as it is possible with the

* Dr. William A. Monkhouse, Medical Director of the N. E. S. B. C., felt that this article would be of interest to fellow members of the Maine Medical Association in view of the fact that shipyard workers come from towns all over the State, and a doctor not engaged in industrial work is usually not too familiar with the effects of working conditions such as are present in large industries of this type, and are prone to attribute a great many illnesses to industrial exposure.

** Presented before a meeting of the Cumberland County Medical Society held in Portland, Maine, November 24, 1944.

coated rods consistently to make better and stronger welds at much higher speeds.

Like many industrial processes, welding has evolved a terminology of its own. Both direct current and alternating current are employed at the arc. When direct current is used polarity must be considered. When the base metal is made the positive terminal and the welding electrode the negative, the hook-up is called "straight" polarity. Conversely, when the base metal becomes the negative terminal and the welding electrode the positive it is called "reverse" polarity. These words may be confusing to the uninformed but are accepted usage in the welding fraternity.

Alternating current is employed at the arc in both large and small welding sets such as for production and repair work, especially in small shops. These sets usually use standard commercial 60 cycle circuits. Rods are now available for use with either A. C. or D. C. sets.

So far as health problems go, it makes no difference whether the set is A. C. or D. C., or whether reverse or straight polarity is used.

Shielded arcs and coated electrodes. The so-called shielded arc is produced by special coatings baked on the welding electrode. Some of this coating burns to form a protecting gas shield around the molten metal as the metal passes across the arc, while the mineral portion of the coating forms a protective slag on top of the molten metal. Thus there is less oxidation of metal, less formation of nitrides, the metal cools at the proper rate, and the work is done faster than is the case with bare electrodes. From the practical standpoint, virtually all production welding today is done with coated electrodes.

Welding Electrodes. In the Welding Handbook[4] of the American Welding Society, one will find an excellent chapter on electrode coatings, weld metal, and slags. From this book we have drawn freely. Knowing our interest in the hygienic aspects of welding, the Welding Committee of the National Electrical Manufacturers Association obtained from its members the composition of their welding electrodes and coatings.[3] The production of the firms contributing represents over 90% of the welding electrodes made in the United States.

Welding electrodes are designated by various trade names corresponding to numbers assigned by the American Welding Society. Some of these numbers and their use in steel fabrication are as follows:

Number E 6010 is an all-position direct current reverse polarity electrode. It is used on common steel and galvanized iron. In the first quarter of 1944 it comprised about 48% of the welding electrodes used in the United States. Number E 6011 is used on A. C. welding and in all positions (vertically, overhead or horizontally) but accounts for only 2% of the total. Number E 6012 and E 6013 are known as cold electrodes and are used on straight polarity or on A. C. and account for 30% of the total used. Numbers E 6020 are commonly called "hot rods" by the welders because they are used at high current densities resulting in high burn-off rates and deep penetration. They are adapted especially for downhand or filet work, A. C. or D. C. They comprise use about 10% of the total output.

Stainless steel electrodes were developed for welding corrosion-proof tanks and stainless steel of various kinds. They are used also on certain kinds of armor plate. They account for about 5% of the total, while various special non-ferrous and ferrous alloy electrodes account for the balance.

The composition of the wire used in all of the E 6000 or mild steel and the stainless steel electrodes is given in the following table:

Table 1. Analyses of wire in mild steel and stainless steel welding electrodes.

Wire Analysis	Mild Steel (E 6000)	Stainless Steel
C	0.7 -0.25%	0.07-0.25%
Mn	0.40-0.60%	0.40-2.5%
Si	0 -0.30%	0.20-0.60%
S	0-0.035%	0 -0.035%
P	0-0.035%	0 -0.035%
Cr		18 -26%
Mi		8 -21%
Fe	Balance	Balance

The coatings used for these same types of electrodes are likewise controlled within limits but it is permissible to vary the ingredients somewhat. In Table Two we give a summary of the analyses assembled for us by the welding electrode manufacturers.

Table 2. Analyses of coatings in mild steel and stainless steel welding electrodes.

Electrode Coatings	American Welding Society Types E 6010	E 6011	E 6012 E 6013*	E 6020 E 6030	Stainless
H_2O	Under 10%	Under 10%	Under 10%	Under 10%	Under 10%
Sodium silicate	30-40%	25-35%	10-20%	10-20%	15-20%
Cellulose	20-30%	20-30%	3-10%	Under 5%	
$MgSiO_3$	10-25%	15-30%	10-20%	5-20%	Under 10%
TiO_2	10-20%	10-35%	30-50%	Under 6%	Under 10%
Ferro Mn	10-20%	5-10%	Under 10%	5-20%	Under 10%
MgO		5-10%	Under 5%	Under 5%	
ZrO_2		Under 5%	Under 5%		
Al_2O_3 (clay)		5- 7%	5-11%	Under 10%	
SiO_2			15-20%	10-30%	Under 15%
Feldspar			10-20%		Under 10%
Mica				10-20%	
$CaCO_3$				Under 10%	20-30%
Iron Oxide				15-30%	
MnO_2				10-25%	
CaF_2					20-30%
Mn					Under 10%
Mo					Under 5%
Cr					Under 5%

* Note: E 6013 same as E 6012 except cellulose may be up to 25%.

There are several items in Table Two which need explanation. The moisture content is not constant, as the temperature at which the coatings are baked can be varied over a considerable range. Sodium silicate is the binder which is common to all coatings. Magnesium silicate, clay, asbestos, mica, and feldspar are used variously. Thus, a manufacturer can use the mineral feldspar or he can use a combination of several silicates to give substantially the same result. Titanium dioxide, usually as the mineral rutile, is a common agent for arc stabilization and may contain some zirconium dioxide as an impurity. Manganese, as ferro-manganese, is added as a deoxidizer. Silica is not used as such but is present both as a mineral silicate and in sodium silicate. Calcium carbonate as limestone is used for slagging and is especially important in the stainless steel electrodes. These latter all contain calcium fluoride, usually as the mineral fluorspar.

In mild steel welding with all of the E 6000 electrodes, the fumes evolved contain[4] about 60 to 70 percent Fe_2O_3-TiO_2 from 10 to 30 per cent SiO_2, and from 2 to 12 percent MnO_2.

When welding on galvanized iron, the total fumes increase with the introduction of some 65 percent ZnO and a corresponding drop in Fe_2O_3-TiO_2, MnO_2, and SiO_2. In welding with stainless steel electrodes, the total weight of fume is about the same as for mild steel welding but the analysis is quite different. The following is typical of fumes from stainless steel:

SiO_2	5.8
F	17.6
Fe_2O_3	16.1
Cr_2O_3	8.3
NiO	2.3
CaO	9.7
MnO_2	2.8

Gases evolved in welding. Both the electric arc and the acetylene torch fix some nitrogen from the air as oxides, the exact amount varying with operating conditions. One of these oxides, NO_2, is a lung irritant. It was pointed out previously that one of the functions of the coatings of modern welding electrodes was to prevent reaction of the weld metal with the oxygen and nitrogen of the air. It has been shown[5] that

less NO_2 is formed with the coated than with the uncoated electrodes.

Carbon dioxide and water vapor are evolved in welding with coated electrodes but carbon monoxide in hygienically significant amounts has not been reported, so far as we know. In explaining the shielding action of the products of combustion of the coatings, welding experts suggest that CO is formed and then converted to CO_2 on leaving the immediate vicinity of the arc.

Theoretically hydrofluoric acid, HF, could be evolved from the coatings of the stainless steel electrodes. We burned a great many such electrodes recently in response to complaints about the irritating nature of the fumes and found no HF. However, fluoride compounds are, of course, present.

The health effects of breathing welding fumes.

I. *Zinc oxide.*

Every welder knows what happens if he breathes excessive doses of zinc oxide, ZnO, from welding on galvanized iron. We have had some reports of metal fume fever come from physicians who are unaware of the significance of the chronology of events which accompany a typical attack of metal fume fever. Therefore, we reproduce a simple chart which illustrates this chronology,[6] in figure one.

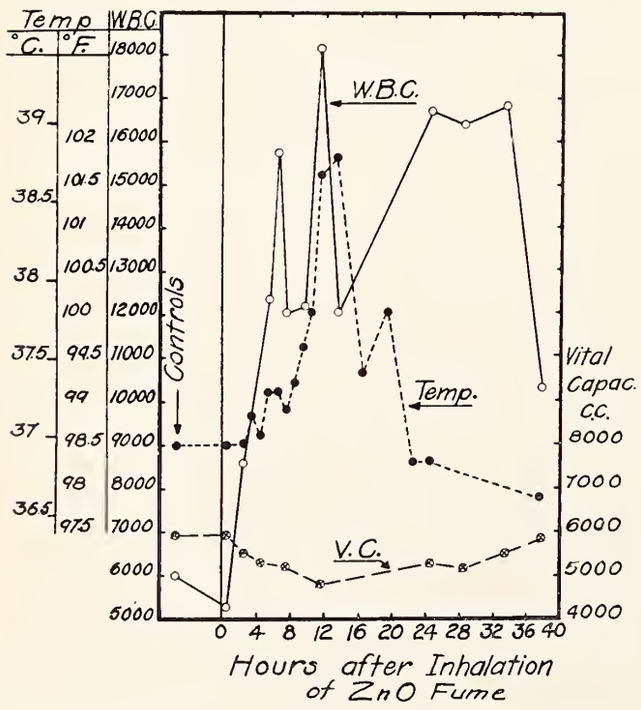

Figure 1. A typical attack of metal fume fever, showing increase in leukocyte count, body temperature, and drop in vital capacity. Note that fever abates before the white count returns to normal.

(After Sturgis, et al., courtesy *J. Indust. Hyg. and Toxicol.* [9:88, 1927].)

Following inhalation of enough zinc oxide the body temperature gradually increases, reaches a peak in about 6 to 8 hours and is back to normal in about 24 hours. Leucocytosis appears a little earlier and remains present a little longer than the pyrexia. No therapy so far reported is of the slightest avail—we have tried hot baths and steam baths, milk, antipyretics, and various beverages both alcoholic and non-alcoholic. A certain resistance persists for the duration of the leucocytosis and this perhaps accounts for the common industrial observation that attacks of the fever are unlikely on two successive days.

Sometimes the metal fume fever attacks induce severe coughing which may cause vomiting, but this is not common. It has been reported, however, fairly often, as it is apt to worry the men more than anything else they experience in the course of such an attack.

II. *Iron oxide.*

Enzer and Sander[7] and Sander[8] studied a group of 26 electric arc welders, who had each welded an average total of 19 years. Of this period the last 2 or 3 years had been with coated electrodes and prior to that with bare rods. Much of this welding had been in steel tanks ranging in capacity from 500 to 3,000 gallons. Each tank had two openings, one 11 x 18 inches and the other 3 inches in diameter. Welding of the inside seems of these tanks produced an accumulation of dense fumes and exhaust ventilation was used only during the last two years. X-ray examination indicated that these workers could be divided into three groups: (1) 5 welders with nodular shadows simulating a modified type of silicosis, (2) 5 welders with trunk shadows markedly exaggerated, and (3) 16 welders with perfectly clear lungs. Histories revealed that group (1) had spent the most time in the tanks, group (2) a moderate amount of time, and group (3) the least time of all. In none of the 10 men with X-ray changes were there any chest symptoms, evidence of tuberculosis or history of exposure to silica dust. These authors obtained post-mortem material from one of their cases who

died following an injury. This man had welded with bare rods for 18 years, with coated rods for two years and had welded in the above tanks for 8 years. One year prior to his accident the chest roentgenogram showed fine nodulations uniformly distributed in both lungs, exaggerated trunk shadows but no conglomeration or calcification. Lung sections revealed a fine black pigment, demonstrated to be iron, distributed throughout but with entire absence of scarring or of fibrous nodulation. These authors conclude that:

1. "Deposition of iron oxide in the lungs is responsible for the X-ray appearance of nodulation in certain welders who have used bare metal electrodes over a number of years.
2. Unless the work is very confined, causing massive concentrations of particulate iron in the fumes, deposition to an appreciable degree does not seem to occur.
3. Attention is called to the striking similarity of the X-ray appearances due to the deposit of iron oxide with those due to silicotic nodulation.
4. Functional impairment of the lungs with such iron deposits appears to be entirely lacking, both as to the development of clinical symptoms or susceptibility to complicating infections."

Groh[9] studied a group of 83 men who had been welding most of their working years. Welding fumes in the plant were exhausted by an overhead hood which drew the fumes through the breathing zone of the welder. After eliminating all workers with a history of silica dust exposure, 71% of this group on X-ray had fine nodules uniformly distributed throughout the lung fields but with normal linear markings and hilar regions. There were no thickened septa or pleura, fibrosis, pericardial or diaphragnatic adhesions or inflammatory reactions and except for the nodulations the lungs were perfectly normal. The average exposure to welding correlated well with the roentgenograms, for those with normal lungs had welded 6.7 years, with slight nodulation for 8.5 years and with extensive nodulation for 9.2 years. The author is of the opinion that " . . . there is no evidence which suggests any disability from this exposure nor any evidence which suggests any possible future disability from the condition" and concludes that:

1. "Arc-welder's siderosis is a well established condition.
2. It is not necessary that the poorly aerated space in which the welder is exposed to high concentrations of welding fumes be small.
3. Arc-welder's siderosis has not predisposed to tuberculosis or reactivated old calcified lesions in the lungs in this group of welders.
4. All evidence to date indicates that arc-welder's siderosis is not a hazard to the health of a workman, but a serious potential menace to the mental stability of the welder if not soundly evaluated by the physician and intelligently interpreted to the affected welder and to the prospective employer."

It has been our experience in shipyards having contracts with the U. S. Navy, U. S. Maritime Commission and War Shipping Administration that where welders work in a dense concentration of iron oxide welding fumes without adequate ventilation, a transient upper respiratory irritation may develop. Such a welder may expectorate grey-black or rusty sputum. It is important to realize that ferric oxide (Fe_2O_3) is reddish brown and produces this rusty color of the sputum. This may be demonstrated by chemical examination of the sputum and by the finding that blood is chemically absent from the sputum. There may occasionally be slight traces of blood in the sputum due to the exertion of coughing or clearing the throat, but there will not be enough blood to impart a red or rusty color to the sputum. The irritation produced by the deposition of iron oxide particles on the pharynx and tracheal passages may cause a cough. There is no proof that any known concentrations of iron oxide ever produce metal fume fever similar to that caused by zinc oxide. The above types of irritation are transient and disappear when adequate ventilation is supplied.

III. *Chromium oxide.*

Chromium oxide may occur in the fumes from the welding of stainless steel or of armor plate where the welding electrode is high in chromium. While experimental data are lacking, it is our belief that dense concentrations of this type of fume may produce in some workers a dermatitis similar to that caused by zinc chromate paint. Adequate ventilation will prevent the occurrence of this type of dermatitis.

Another source of chromium fumes is the welding or burning of metal coated with zinc chromate paint. At the U. S. Naval Research Laboratory, the Division of Industrial Hygiene of the National Institute of Health, U. S. Public Health Service collected with an impinger, samples of fumes from the acetylene burning of steel plates coated with zinc chromate paint. Under normal working conditions and without artificial ventilation they found the highest concentration of CrO_3 to be .011 mgms. per cubic meter of air. The maximum allowable concentration of chromic acid established by the American Standards Associations is 0.1 mgm. per cubic meter of air for exposures not exceeding a total of 8 hours a day. Since this work indicates that only one-tenth of the permissable allowance was produced, it is not believed that welding or burning of zinc chromate paint constitutes a significant industrial hazard.

IV. *Lead Oxide.*

The signs and symptoms of lead intoxication are sufficiently well known and need no description here. Lead does not occur as a component of welding electrodes or their coatings and therefore, the welding of bare steel does not produce lead fumes. However, in the construction of merchant ships both in the past and today, considerable red lead paint is used to prevent corrosion by salt water and when surfaces coated with red lead paint are burned or welded there is a lead hazard. The U. S. Maritime Commission now requires that where red lead painting must precede welding during ship construction, that a six-inch wide strip on both sides of the proposed future weld be left bare until welding is complete. It is not possible to observe this precaution in repair and conversion shipyards for the ship has been painted long before it reaches such a yard. In all cases where it is necessary to burn or weld red leaded surfaces we strongly urge the use of adequate ventilation to remove the lead fumes. For an occasional exposure, workers should wear respirators approved by the Bureau of Mines for use against metal fumes.

V. *Miscellaneous.*

The coatings of electrodes used in the welding of stainless steel and armor plate are high in calcium fluoride. While experimental data are lacking, it is believed that where the welder works in dense concentrations of this type of welding fumes with inadequate ventilation, there may develop upper respiratory tract and conjunctival irritation. With adequate ventilation, this irritation does not occur.

It is not believed that manganese, molybdenum, nickel, titanium or silion constitutes a health hazard in welding fumes.

VI. *Pneumonia.*

Fatal pneumonias have been reported following a few instances in which men welded in relatively confined spaces without ventilation. But such occurrences are uncommon. The cause has been ascribed to the NO_2 gas, a powerful lung irritant. The evidence blaming NO_2 is not altogether convincing but in the few cases reported, there is no other reasonable explanation.

A recent study of some 864 cases of pneumonia in the Richmond, California, yards of the Kaiser Corporation made by Collen, Dybdahl, and O'Brien,[10] showed that pneumonia was no more common among welders than among other crafts in the yards. They found, further, that the fatality rate was about the same for all shipyard crafts. Their data are shown in the following table:

Relationship Between Incidence of Pneumonia and Occupation

Occupation	No. Cases	No. Deaths	No. Employed	Morbidity Rate per 1,000
Welders	159	14	15,533	10.2
Shipfitters	74	11	7,998	9.3
Flangers	60	6	4,842	12.3
Laborers	53	5	4,923	10.8
Burners	42	2	4,389	9.6
Electricians	41	2	3,575	11.5
Pipefitters	38	5	3,117	12.2
Machinists	36	4	3,153	11.4
Shipwrights	29	1	2,768	10.5
Chippers	24	1	3,076	7.8

Ventilation in welding. In open shops it often is not necessary to use local exhausts. The general ventilation of the building may suffice. If production work is to be handled, such as pipe welding, it usually speeds up production to apply local exhausts with flexible hose. We have many such installations in our shipyards all over the country. Neither management nor labor would dispense with them.

In ship construction, both general ventilation and local exhausts are used. We admit that the intelligence and effectiveness with which ventilation is applied varies greatly. We have some yards where it is excellent and others where definitely it is not. As a guide, we recommend local exhausts drawing about 200 cubic feet per minute per welder with the exhaust hood placed within 8 inches of the work.

Where general ventilation is the method used we recommend at least 400 cubic feet per minute per welder.

In galvanized iron welding, we suggest that concentrations of zinc oxide in the air breathed be kept below 15 mgs. per cubic meter. We have yet to hear of metal fume fever being caused at concentrations below 15 mgs.[11]

In welding mild steel, we suggested concentrations of Fe_2O_3 below 30 mgs. per cubic meter.[12] Since Fe_2O_3 of itself causes only slight discomfort or reaction, the 30 mgs. is simply an empirical figure suggested as the easiest yardstick for estimating adequacy of ventilation. In shipyard work, we have had no complaints when air pollution was below 30 mgs. We have had plenty of complaints when it exceeded this figure by an appreciable amount.

We have no figures for permissible pollution from welding with stainless steel. From experimental work, we know the fume is no harder to catch than that from welding with mild steel so that we recommend the same local exhaust ventilation—at least 200 cubic feet per welder per minute.[12] From limited trials, we believe that the 30 mgs. of Fe_2O_3 per cubic meter will serve as well for the stainless steel as for fumes from mild steel.

The conclusions which we believe can be drawn from welding work all over the country are that when good ventilation is enforced, there will be no trouble. When ventilation is ignored, especially on galvanized iron and stainless steel, justifiable complaints will be made.

In order to obtain more information on the effects of welding fumes, the U. S. Public Health Service, U. S. Navy and U. S. Maritime Commission are conducting a joint health survey in eight shipyards. Four of these yards are on the East and Gulf Coasts and four on the West Coast. A total of 5,000 workers will be examined, approximately 600 in each yard. Each worker is given a thorough physical examination, including chest X-ray, blood test and urinalysis. Four medical officers from the U. S. Public Health Service and U. S. Navy are conducting these examinations. The workers to be examined are selected in advance by a statistician from the U. S. Public Health Service, in order that various occupational crafts may be represented as well as both male and female workers.

In addition there are five engineers and chemists from the U. S. Public Health Service and U. S. Navy who take samples of the various gases and fumes given off during welding. These samples are taken during ship construction and represent the actual conditions to which welders and all nearby workmen are subjected. They therefore, give a true picture of any health hazards arising from exposure to welding fumes. In this way, a correlation may be obtained between what the engineers find in the fumes and what the physicians find in the workers.

This survey is now about half completed and will be finished during the fall of this year. At that time all of the medical and engineering data will be carefully analyzed and about January 1, 1945, a report will be published by the U. S. Public Health Service. This report will be given wide-spread distribution and can be obtained by all those who desire it.

Footnote

The Maritime Commission and Navy have prepared a sound strip film, "Welders—To Your Health!" We have found the film very helpful in teaching both workers and management the advantages of good working conditions for welders. Copies of the record and film are available by addressing Health Consultants, U. S. Maritime Commission, 1015 Chestnut Street, Philadelphia 7, Pennsylvania. It can be seen at most of the shipyards in the country.

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*A Trustee Looks to the Future**

By Raymond P. Sloan, Editor, "The Modern Hospital," New York

Never was there a time when crystal gazing was quite as popular as it is today. It has become, in fact, the favorite indoor sport of many. As might be expected, too, each one sees revealed in the clear depths something different —his own interpretation of the world as it is to be in days to come and the role he is to play in it. Wasn't it Mark Twain who remarked, "Crystal gazing gratifies some people and astounds the rest."

This is merely to explain that I, too, have done my share of crystal gazing and from shadowy images have conceived a picture of hospital and health services in the future. Let me emphasize that it is my own conception, an answer to certain questions that have been challenging me over a long period. I would not ask you to accept it in whole or in part even. I do not venture to predict its fulfillment. If it provides you with some inspiration on which to create your own design for a hospital and health pattern after this harassed world settles down to some sort of order, I shall rest content.

I would remind you that I am speaking to you as a trustee, which carries with it increasing responsibilities these days. In fact, my whole picture centers about the trustee for is it not he who must chart the paths of our philanthropic institutions and direct their destinies. How poorly he has been prepared for his task. What could we have been thinking of to overlook him so completely all these years. He has been a guardian in name only. So busy have we been in raising standards elsewhere, getting our institutions approved, and building to certain professional specifications, that we have given little thought to his qualifications, his attitudes, his vision, his thinking. It is not his fault if he has remained ineffectual. The importance of his functions has never been completely realized. Little has been done to raise the standards for hospital trustees.

It is all very different in my picture. No longer do hospitals gain approval through measurements applied to their professional staffs alone but through measurements applied to their boards as well. For how can an institution achieve its full potentialities and be thoroughly sound under government that is unstable, unwise, inefficient. I would scrutinize the actions of a hospital board as carefully as I would follow the procedures of its medical staff before saying "yes" or "no."

Fewer but better hospital trustees appear in my post-war picture. Nowhere, or hardly anywhere, do I see cumbersome boards of 30 or more. Eight or ten individuals assume the major responsibilities, the rest remaining as friends of the hospital about whom we shall hear more later. By better trustees I mean better prepared for their responsibilities. Hospital training programs might well start at the top and work down instead of contrari-wise. No longer can the trustee remain the forgotten man.

In these men and women of my picture we discover a curious combination of realism and idealism. They interpret hospital and medical care as a public utility rather than as a charity. But a public utility conducted for service rather than for profit. Basic social attitudes and philosophies are far more important than any individual service they may offer as bankers, lawyers, engineers and such. Such counsel can be purchased; social values and ideals cannot. Proper balance between the two is an ideal solution, of course.

These trustees are truly representative of the community, speaking authoritatively in terms of labor, religion, politics, but without bias, discrimination or egotism. They are realists who recognize the need of providing the community with the best possible health service at the lowest possible cost. Consequently they visualize the hospital as a center for medical care and health education with over-expanding facilities for diagnostic and therapeutic services. They see the potential of group medical practice as exemplified either by an organized medical staff or by general practitioners and specialists serving under one roof. They see the benefits of

* Read at the Annual Meeting of the Maine Hospital Association, Waterville, Maine, June 23, 1944.

such facilities extended to private patients also to the medically indigent for whom paid clinics shall be provided. Their health program is all embracive including provisions not merely for the acutely ill, but for chronic illness, convalescence and geriatrics.

Throughout my post-war picture groups—community groups, industrial groups, public health groups, hospital groups, medical groups—strive collectively for better health standards. I can think of no better slogan for such concerted effort than that which appears under the name of your own Maine Hospital Association—"Together, for Others." Those three words which imply so much might well appear under the name of every hospital association or council.

Closer integration and regionalization of hospital service is inevitable, with smaller out-post hospitals affiliated with certain larger central hospitals and medical units. In your own state new trails have been blazed in this direction through projects sponsored by the Bingham Associates which center about the Central Maine General Hospital in Lewiston and Eastern Maine General Hospital in Bangor. Such achievements will spread to other sections. Noticeably absent from my picture are numerous small hospitals fighting with one another for patients and with no apparent good reason for their existence. They continue to serve, some of them, but as part of a carefully conceived health plan.

I am hoping that the motivation for such group planning may come from within the hospital field rather than from without. And, I believe, that it will, provided we recognize trends and prepare to meet them.

Among the groups playing an important part in my post-war picture is industry. Already we find industry participating actively in health programs. Mr. Kaiser of shipbuilding fame in his fine new hospitals on the Pacific Coast, particularly the Permanente Foundation Hospital at Oakland, has produced health, and dollars, through group medical practice.

But this is merely a war-time expediency you say. Mr. Kaiser has provided hospital facilities where there were none, or at best few. True, in one sense, but is it not logical that from many war-time measures we shall evolve a pattern that will be lasting. If industrial leaders in this country are convinced that under their auspices and through some sort of medical group practice as set up by Mr. Kaiser, better health can be provided for their workers and their families, on a sound economic basis, they will bring pressure to realize it. A question that should concern us, I believe, is what would have happened if there had already been adequate hospital facilities in that community where Kaiser established his Permanente Foundation.

Group practice in a different form is revealed at the Mary Hitchcock Memorial Hospital in Hanover, New Hampshire, where it is making a definite contribution toward providing proper distribution of adequate medical care on an efficient basis and, therefore, at lower cost. Here the hospital is the physical hub of the wheel. The hospital staff of five men was organized as a group clinic in 1927. Three of the five founders are still in active practice and 17 more have been added. Almost every variety of practice is within the activities of this group. There are no practicing physicians in the local community outside of the clinic.

To go back to industrial support, another trend which obviously is less challenging, is revealed in Hartford, Connecticut, where over $2,000,000 was secured from such sources for the building program of the Hartford Hospital. This uses existing hospital facilities as a basis for the health program but without group medical practice.

Perhaps some of these industrial leaders whose names appear among our voluntary hospital trustees, will start asking questions and will influence the more adamant among us to change our thinking to conform with a changing world. Perhaps better yet, we will start now to do some thinking on our own about these various trends.

Not only must we do some thinking but we must do plenty of talking about the services of our voluntary hospitals. So comparatively few people know what these institutions actually are accomplishing in research and health education. If ever a press agent, so called, were needed it is in this field.

Looking into my crystal I see hundreds—thousands of men and women qualified to present the story of the voluntary hospital speaking before community groups and explaining to

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Editorial

Physical Fitness Must Be Started Before Birth

The improvement of physical fitness must begin before birth with proper prenatal care and extend through infancy, all of the school years and into adulthood, Morris Fishbein, M. D., Chicago, declares in the December issue of *Hygeia, The Health Magazine*. He points out that the development of such a program demands a nationwide participation and depends for its success on the coöperative efforts of physicians and all the accessory medical professions, physical educators, health educators, industries and the general public. In his editorial on "The Health of American Youth," Dr. Fishbein says:

"The publication of the statistics relative to rejections under the Selective Service System has brought about a number of criticisms, often unjustified, of some of the agencies concerned with the nation's health and fitness. Hearings before Senator Pepper's Committee gave opportunity for public presentation of these figures, which were used by some of those who testified as an attack on the medical and dental professions. The claim was made that medicine and dentistry have failed because a considerable number of boys failed to meet Selective Service standards. The significance of these failures was not clearly explained.

"Many a young man who failed to meet Selective Service standards for the armed forces is still at work doing a big job in American industry, perhaps playing on professional baseball or football teams, occasionally seated at a desk in an executive position of great productive value for the community. The existence of uncorrected hernias, flat feet, perforated eardrums, asthma and hay fever, which disqualify a man for military service, may be of little significance in a civilian capacity.

"As is pointed out by Dr. R. L. Sensenich in this issue of *Hygeia,* many of the rejections were in the field of illiteracy or for mental defects in which the services of medicine were not primarily related. Approximately one out of six men was rejected because of remediable defects. Often failure to secure remedy was due to lack of interest or willingness to accept treatment to correct conditions rather than inability to obtain needed medical services.

"At a meeting of the Governing Council of the American School Health Association, recently held in New York City, a statement was adopted disclaiming the responsibility of the school in relationship to rejections for lack of physical fitness. In its statement the American School Health Association says:

'The American School Health Association feels that the marked tendency to blame the lack of adequate physical fitness upon the schools is most unfortunate and not a fair appraisal of the causes.

'True physical fitness can be acquired only through a combination of heredity, the diagnosis and correction of deficiencies in early youth, intensive instruction and habituation in a multitude of knowledges and practices in health matters, and a building of muscular power and stamina through physical activities and recreation preferably out of doors. Such a program will create not only physical fitness, but a stability of mental attitudes and practices so notably lacking in our youth that it has been necessary to reject thousands of them from the armed forces.

'Moreover, the figures on rejections indicate clearly that it is the defects in older age groups that make the rates of rejections so high. Among those recently from our schools the rejection rate is low. Among those over the age of 30 it is enormous. In other words, it seems clear that the attitudes and habits of the individual after leaving school are the most potent factors in his physical deterioration.'

"Furthermore, the *Journal of School Health* comments editorially in its issue for October, 1944, pointing out that the schools are certainly not to blame for the feeble-minded, for the psychoneurotic and the psychotic. Can the schools be blamed for those rendered unfit for military service because of the effects of infantile pa-

ralysis, rheumatic fever, diabetes, accidents, hernia, faulty vision or tuberculosis? To what extent are the schools responsible for defective teeth, overweight and underweight or deviations in skeletal and muscular development? An analysis of the rejections by ages shows strongly that the longer a man has been away from school, the higher the rejection rate in practically all categories. Of all causes for rejection the skeletal and muscular cases seem to be the group that might be benefited by a greater physical activities program in the schools. True, the total among the whole number of rejections is small. Dr. Charles H. Keene, editor of the *Journal of School Health,* feels that intensive instruction and habituation in the field of healthy living, in safety measures and in the control of infection would be of far greater value to students generally than any other type of education in the field of health and physical fitness.

"An analysis of the situation as it relates to the physical fitness of American youth indicates that the problem demands a multiple approach. Improvement of physical fitness must begin even before birth with proper prenatal care, extend through infancy with an immunization program that might prevent infectious diseases of childhood and their crippling complications, and go on through the nursery and kindergarten, where sound habits of nutrition begin to be established, carry through grade school, high school and college, in which sound instruction in health habits and physical activities, including competitive sports, should be integrated in the curriculum. Finally, when the boy or girl has left school there must be continuing participation in healthful living, sports and recreational pastimes to maintain the physical fitness that the schools have established. The development of such a program demands a nationwide participation and depends for its success on the coöperative efforts of physicians and all the accessory medical professions, physical educators, health educators, industries and the general public."

The Health Hazards of Welding Fumes—*Continued from page 229*

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See also: Minimum Requirements for Safety and Industrial Health in Contract Shipyards. U. S. Navy and U. S. Maritime Commission, 1943.

Note

Views expressed are those of the authors and are not to be considered as those of the Navy Department.

Committee Appointments

Standing Committees

Cancer

The Council of the Maine Medical Association at a meeting held in Augusta, Maine, November 5th, appointed Julius Gottlieb, M. D., of Lewiston, Chairman of the Cancer Committee to succeed Mortimer Warren, M. D., deceased.

Joseph E. Porter, M. D., of Portland, and Forrest B. Ames, M. D., of Bangor, were appointed to serve on this Committee with the members elected at the meeting of the House of Delegates in June, whose names were published in the July issue of the JOURNAL.

Special Committees

R. V. N. Bliss, M. D., President of the Maine Medical Association, has appointed the following Special Committees as suggested at the meeting of the House of Delegates of the American Medical Association held in Chicago, June, 1944.

War Participation Committee

Oscar F. Larson, M. D., Machias, Chairman
Roland L. McKay, M. D., Augusta
Charles W. Kinghorn, M. D., Kittery

The War Participation Committee of the American Medical Association originated from the report of the 1941-42 Committee on Medical Preparedness to the 1942 House of Delegates. The latter Committee suggested that it be discontinued and a new Committee created for the purpose of keeping in close touch with all war related policies affecting the quality and efficiency of medical service both to the armed forces and to the civilian population.

The Chairman, Dr. Walter F. Donaldson, of Pennsylvania, has suggested that the various State Medical Societies create a Committee known as the War Participation Committee. The State Committee could coöperate with the National Committee along many lines; for example (1) maintainance of war records of physicians in military service, (2) preservation of the local economic and professional interests of absent members, and (3) preparing now to implement promptly at the conclusion of the war the plans currently being laid by the Committee on Postwar Medical Service of the American Medical Association and related organizations.

Medical Service and Public Relations

Henry C. Knowlton, M. D., Bangor, Chairman
John O. Piper, M. D., Waterville
Carl M. Robinson, M. D., Portland

The Council on Medical Service and Public Relations of the American Medical Association was created by the House of Delegates in June, 1943.

In order that constituent associations and component societies may be kept informed of the activities of the Council and of proposed changes in the status of medical care, and the Council may be of assistance to those associations and societies, the Council has requested

each State Association to designate an existing committee or create a new committee to function with the Council on the state level.

Dr. John H. Fitzgibbon, of Portland, Oregon is Chairman of this Council. The central office of the Council is located in the office building of the American Medical Association, in Chicago, and a Washington Office was opened April 3, 1944, at 1935 Eye Street, N. W.

State of Maine Committee on Nutrition

Doctor Bliss has appointed Maurice A. Priest, M. D., of Augusta, to represent the Maine Medical Association on the Committee on Nutrition. Professor Marion D. Sweetman, of the University of Maine, is State Chairman.

A Trustee Looks to the Future—Continued from page 231

them what it is all about. The same procedure applied to voluntary hospital insurance would, I believe, help more than anything in boosting membership in our Blue Cross Plans and thus eliminate the need of a government system. We need to become audible. For too many years we have sat back and taken what has come. Who shall defend our voluntary hospitals if it is not ourselves.

These men and women, boosters, speakers, publicists for the voluntary system, are now among our volunteers. Already we hear the question raised "What about volunteers in the post-war era?" What jobs can we find for them when paid employees are again available. Here we have the answer. They know—these men and women who have served as orderlies and nurses' aides. They have learned the hard way —through practical experience. Now let them go out and describe what they have seen, the many needs that they know exist, what voluntary hospital service means to the average man and woman.

Here then is another important group in my post-war picture—volunteers. Of course, we shall always have them; of course, we shall always need them if for different purposes.

I see two types of community groups supporting our hospitals. First the volunteer group comprising men and women who will render active service of one type or another. In this category will fall the functions of women's auxiliaries, which for so many years have rendered valiant support. Surely there could be no more tireless workers for the hospital than these public-spirited women.

Then I see a second group, an even bigger and broader group comprising an auxiliary or society of the hospital which will include volunteers as well as those unable to render personal service—supporters of the hospital nevertheless who will participate as members through sustaining dues.

It is entirely conceivable that from the ranks of these volunteers and auxiliary members promising material may be secured for the governing board or trustees. But no action shall be taken until they have proved their worth. Again, fewer but better trustees is our aim.

These various groups — community, industrial, public health, medical — speak in terms of the modern hospital which I have previously described as a medical and health education center. Not only does it provide beds for the sick but diagnostic and treatment clinics, offices for the medical staff, headquarters for visiting nurses, accommodations for the department of health and, of course, laboratories for research.

Finally, I see in my crystal a great nation-wide body of hospital trustees, volunteers and friends constituting public opinion for our institutions. These men and women will speak with authority when our voluntary charities are challenged and will hold regional and national rallies on occasion. They will comprise the privileged, also the under-privileged, men and women from every rank of life, who will serve without bias of race, color or religion. And as their motto they will adopt these words—"Together for Others, for the good of all mankind."

COUNTY SOCIETIES

Androscoggin
President, Daniel F. D. Russell, M. D., Leeds
Secretary, Leroy C. Gross, M. D., Auburn

Aroostook
President, Clyde I. Swett, M. D., Island Falls
Secretary, Thomas G. Harvey, M. D., Mars Hill

Cumberland
President, Albert W. Moulton, M. D., Portland
Secretary, Joseph E. Porter, M. D., Portland

Franklin
President, Albion E. Floyd, M. D., New Sharon
Secretary, George L. Pratt, M. D., Farmington

Hancock
President, Philip L. Gray, M. D., South Brooksville
Secretary, Edward Thegen, M. D., Bucksport

Kennebec
President, Clarence R. McLaughlin, M. D., Gardiner
Secretary, Clair S. Bauman, M. D., Waterville

Knox
President, Herman J. Weisman, M. D., Rockland
Secretary, Paul A. Millington, M. D., Camden

Lincoln-Sagadahoc
President, Rufus E. Stetson, M. D., Damariscotta
Secretary, William A. Purinton, M. D., Bath

Oxford
President, H. Louella Noyes, M. D., Rumford
Secretary, J. S. Sturtevant, M. D., Dixfield

Penobscot
President, Manning C. Moulton, M. D., Bangor
Secretary, Forrest B. Ames, M. D., Bangor

Piscataquis
President, Albert M. Carde, M. D., Milo
Secretary, Harvey C. Bundy, M. D., Milo

Somerset
President, Harvey F. Doe, M. D., Fairfield
Secretary, Maurice E. Lord, M.D., Skowhegan

Waldo
President, Foster C. Small, M. D., Belfast
Secretary, R. L. Torrey, M. D., Searsport

Washington
President, Walter N. Miner, M. D., Calais
Secretary, Allen H. Knapp, M. D., Calais

York
President, Waldron L. Morse, M. D., Springvale
Secretary, C. W. Kinghorn, M. D., Kittery

County News and Notes

Aroostook

The fall meeting of the Aroostook County Medical Society was held at the Vaughn House, Caribou, Maine, October 27, 1944, at 7.00 P. M. Seventeen members and seven guests were present.

A lobster supper was enjoyed and the meeting was called to order by the President, Dr. Clyde I. Swett of Island Falls.

Drs. Paul C. LaPorte, Edmundston, N. B., and Sidney R. Gehlert, Jr., Eagle Lake, Maine, were unanimously accepted as members. Greetings from the New Brunswick Medical Society were extended by Doctor Laporte, President. It was voted to have a January meeting in Fort Fairfield and the Chair appointed a committee of four to submit suggestions for frequency and location of future meetings.

The speaker of the evening was Dr. C. H. Lawrence, Chief of the Endocrine Clinic at the Boston Dispensary, Consultant to The Pratt Hospital, and Assistant Professor of Medicine at Tufts Medical College. Doctor Lawrence discussed practical laboratory tests from the general practitioners point of view, with especial emphasis on the cause, diagnosis and treatment of such conditions as overweight in women, dwarfism, skin blemishes and the menopause. He stressed the fact that 98% of the cases of poor complexion yield to present day treatment.

A vivid war picture *D plus 957* was shown by Doctor Swett, and the meeting was adjourned.

T. G. Harvey, M. D.,
Secretary.

Cumberland

The Cumberland County Medical Society met at the Eastland Hotel, Portland, Maine, October 27, 1944. The meeting was preceded by a dinner and was called to order at 8.00 P. M. by the President, Dr. Albert W. Moulton. Resolutions on the deaths of Dr. George M. Woodman, Dr. Charles H. Hunt, and Dr. Julius Calvin Oram, were read.

A short business meeting followed after which the members were entertained by a most interesting paper on *Global Medicine*, presented by Dr. Charles Branch, Dean and Professor of Pathology at the Boston University School of Medicine. Doctor Branch pointed out that he had been sent to Central America last year for the purpose of studying tropical medicine, and was one of several men selected from the Association of Medical Colleges. The trip was sponsored by the Markham Fund, in coöperation with the Army and Navy. The physicians in these groups, who have been sent to Central America, have had the opportunity of studying almost all phases of tropical diseases, and in many instances have been put in charge of laboratories and have been responsible for the therapeutic care of patients in hospitals. Doctor Branch warned that he felt that there was a possibility of returning veterans starting epidemics of malaria, amoebic dysentery, and possible typhus, in this country. These statements he qualified, however, by saying that he felt that the epidemics would not be on any large scale because of the modifying circumstances in the American way of life. The paper was discussed by Drs. Parker, Foster, Scolten, Martin, and Beach.

Joseph E. Porter, M. D.,
Secretary.

Kennebec

A meeting of the Kennebec County Medical Association was held at the Veterans' Administration Facility, Togus, Maine, Thursday, November 2, 1944.

Clinical Session at 5.00 P. M., which was presided over by C. R. McLaughlin, M. D., President:

Subacute Bacterial Endocarditis, Captain Charles Mamoit.

Exophalmic Goitre, Surgical Treatment with Recovery, Major Nathan Rosenberg.

Hyperthyroidism Treated with Thouracil, Dr. Charles Benson.

Brain Tumor, Captain Ralph Dunn.

Discussion on the Neurophysiatric Service by the Clinical Director.

Dinner at 6.30 P. M., which was followed by a business meeting.

Minutes of the last meeting were read and approved.

A Nominating Committee, consisting of Chalmers G. Farrell, M. D., M. A. Priest, M. D., and F. R. Carter, M. D, was appointed by the president to bring in a slate of officers for 1945 to be acted upon at the annual meeting in December, which is to be held at the Augusta State Hospital

The speaker of the evening was Colonel Malcolm Stoddard, manager of the Veterans' Administration, Togus. He outlined the equipment there and spoke of plans being made to care for discharged service men. He said their equipment consisted of a medical and surgical ward, a mental hospital of 1,000 beds and they were in hopes to get a tuberculosis sanatorium. The main office for caring for disabled veterans would be at Togus and they were planning in the near future to open regional offices at Portland and Bangor.

There were 30 members and guests present.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Acting Secretary.

New Members

Aroostook

Paul C. LaPorte, M. D., Edmundston, N.B.
Sidney R. Gehlert, Jr., M. D., Eagle Lake, Maine.

In Military Service

Androscoggin

Rudolph Haas, M. D., Lewiston, Maine

Penobscot

Hans Shurman, M. D., Dexter, Maine

Notice

Maine General Hospital
Medical Grand Rounds

All interested physicians are invited to attend *Medical Grand Rounds* at the *Maine General Hospital* which are now held at *5.15* each *Thursday afternoon* in the *X-ray Department.*

Necrology

Charles W. Bell, M. D.,
1873-1944

Charles W. Bell, M. D., died at his home in Farmington, Maine, October 13, 1944.

Doctor Bell was born in Strong, Maine, January 29, 1873, the son of James H. and Abbie S. Bell. He was educated in the public schools, the Nichols Latin School in Lewiston, and received his Medical Degree from the Maine Medical School in 1897, returning to Strong where he practiced until 1936 when he moved to Farmington and practiced there until his death.

On November 7, 1900, he was united in marriage with Annie B. Stubbs, of Strong, who survives him, together with a son, Richard, of Farmington; a daughter, Mrs. Sarah Folger of Milton, Massachusetts, and a sister, Mrs. Mattie Hinds of Farmington.

He was a member of the Franklin County Medical Society, the Maine Medical Association, the American Medical Association, and was a Fellow of the American College of Surgeons.

He operated a private hospital in Strong for many years, and was a member of the Surgical Staff of the Franklin County Memorial Hospital from its beginning, becoming Surgical Consultant Emeritus in 1939.

He was a member of all the Masonic Bodies in Strong and Farmington, and of the Kora Temple and the Mystic Shrine in Lewiston.

He served as Medical Examiner for Franklin County for twenty-five years.

Doctor Bell's activities extended widely over this section of the State, and he did a large amount of surgery with excellent success, sometimes under the most strenuous of frontier conditions.

He possessed a remarkable faculty for making friends and for inspiring confidence in his patients, and will long be remembered by his colleagues and by all the people of Franklin County.

GEORGE L. PRATT, M. D.

Proceedings

NINETY-FIRST ANNUAL SESSION

Maine Medical Association

ROCKLAND, MAINE

JUNE 25, 26, 27, 1944

First Meeting, House of Delegates Continued from the November Issue of the Journal, Page 222

The adjourned meeting of the House of Delegates of the Maine Medical Association convened at 9.30 o'clock in the morning on June 27, 1944, with President-Elect Bliss presiding.

CHAIRMAN BLISS: The meeting will please come to order. First, we shall have the roll call.

(The roll call by the Secretary revealed a quorum present.)

CHAIRMAN BLISS: We have with us this morning a very agreeable gentleman who, because of our protracted discussion yesterday afternoon, was unable to bring his message to us. But, he kindly remained overnight and he will talk to us this morning. He is going to talk to us with reference to medical care in the Farm Security Administration. Dr. Charles L. Newbury!

DR. CHARLES L. NEWBURY, Regional Medical Officer, Farm Security Administration: Perhaps I ought to say first, that in the armed services, including synthetic majors, we wear dog tags; as a matter of fact, one of them is attached to the body, and the other goes home to the family!

First, I want to pass around to you a report. It was four years ago, I believe, at least it goes back to the days before I had anything to do with the program —so about four years ago, I believe the State Medical Association was approached regarding this program of the Farm Security Administration.

The Farm Security Administration was engaged in rehabilitating the low income families. I think a basic agreement was arrived at, permitting us to approach the county medical societies regarding prepaid medical care. I know that some counties got the wrong impression, and I think that Aroostook County got some wrong impressions.

In the first place, I think the plan was presented to the doctors as an emergency relief affair. I think that it was carried out in five counties to some extent.

The day after Pearl Harbor, I came into this program and was responsible for the relations with other doctors, and we immediately took a different attitude, as naturally one would, in having to deal with doctors instead of laymen.

We take only families who do not get credit elsewhere. If a farmer can get credit elsewhere, he is not eligible.

We loan money to the farmers only, and those farmers have to have some resources to back up those loans. I don't want to go into the philosophy of it. But in Maine today, very largely due to good times, of course, we are loaning only one-third of the money that we are taking back. That has gone on for the last two years. We are collecting the loans from the people who never could pay their debts before.

In other words, it has been possible for us to collect about 90 to 95 per cent of the money loaned to these farmers who are absolutely without credit in the communities.

Now, here are some of the statements from the families regarding the money which they wished to have as a loan. They had to pay debts. And they had to show that they had those debts to pay, before they got the amount of the loan.

We found they owed the doctors on the average of $20.00 a year for medical services, and of that $20.00, they were paying about $8.00. In other words, they were paying 40 cents on the dollar. We took, rather ill-advisedly, that figure of $20.00 as the base regarding medical care. Forty per cent of the farm families in Maine are making only a total of $400.00, so that $20.00 at any one time is back-breaking, but we said that we would collect $20.00 for you at a time when they had the money, and we would put it into a pool, handled by a trustee or trustees appointed by the County Medical Societies, such trustee or trustees to release the money to the doctors at the regular fee schedule, upon presentation of their bills, so much per call or so much for an operation, so much for drugs, whatever arrangement has been worked out with the county medical society.

So the plan did not change in any way the existing means and methods of private practice. It was particularly emphasized that there would be no government control exercised in any way, shape or manner, except that we would loan the money for medical care.

Five counties adopted the plan. At the end of a year, we had a rather disastrous experience. The doctors got 80 cents on the dollar, but unfortunately, some of the doctors had their biggest case load in months, and there was a great demand for their services, so that some doctors got 20 and 30 cents on the dollar in September and October, whereas in July they would have gotten 100 cents on the dollar. The fees had been set too low for the families, although a little bit above the average for the northeast. There was a lot of corrective work that had to be done. There was an increase in the fees paid by the families, and the doctors could get 100 cents on the dollar.

In talking with the county medical societies, we had a very interesting meeting in Piscataquis County; perhaps it could not be considered a real meeting, but all the doctors who could be reached, eight or ten of them, came, even though it was 40 below zero, and got together with a committee of farmers. I reported to the farmers that the doctors had been unpaid, and asked whether they would like to have the fees raised. They promptly agreed. One of the doctors criticised the plan, rather bitterly. "You people are taking in the 'dead beats' and you are rushing into this thing, spending your good money. Why don't you have physical examination fees and take only the well folks that don't need medical care?"

The farmers got up and said: "We thought you doctors were going to take care of sick folks."

"Don't you realize that it is going to cost you 25 per

cent more money? Do you mean to tell me that you don't mind paying for your neighbors' illnesses?"

But they said: "If they are satisfied, we certainly are."

And that experience has been paralleled all over the twelve northeastern states where I work in an advisory capacity. We have never had a complaint that the doctors' fees were too high or unreasonable, or that they were motivated by money. On the contrary, one of the things that makes for the success of the plan is that it is locally administered by the county, instead of at Washington or Philadelphia or Bangor. The doctors can get together with the farmers every month.

Here is Farmer Jones; he made the doctor visit his house twelve times on a simple case of chicken pox. Well, in the monthly meetings, they can thrash that out, and the farmers can be told that they cannot do that with an insurance plan, because the doctors do not guarantee to do everything with an insurance plan. Indeed, there is no responsibility on anybody's part for seeing that the doctor actually gets to the family.

The doctors agree, yes, that they will go along with their regular fee schedule, and should the money prove to be inadequate, they will take a cut. If there is a profit, it will be redistributed. If there is a deficit, they will get together and raise the fees enough to cover the deficit so that in the following year the plan will show a profit.

A doctor said, and it was pretty unanimous among the other doctors: "Well, you have sixty families in this county that you are spending all this time and trouble on. How many other families are just as bad off as these?"

The general figure for the northeastern section is 40 per cent of the families with a total income, including the value of the crops, plus the value of what they eat, of less than $400.00 a year. Obviously, the thing wasn't touching very many.

One doctor raised the point, and it was pretty generally accepted, that a thing like this, to be financially successful, should include enough families to make it pay.

However, I had to say that I was sorry, but that we had a basic agreement with the State Medical Society that we would ask them only for medical care for our own farm families, but that we would go and ask them whether the county societies wanted to do it themselves. Now, in making that suggestion, I recognized the implication of socialized medicine. On the other hand, I want to point out that we can have nothing to do with it in the Farm Security Administration. We are unable to loan money or to devote any time to the building up of the plan. At the same time, I feel it would be more satisfactory, financially, to the doctors. In addition to the raising of the fees, we have asked the doctors to raise their own fees, because in many cases, they were based on something like a welfare schedule, taking in these families so as to make it worth while. Some of the doctors got $90.00 for a year's work, and they attended a meeting of the medical society and made a report every month.

Then, too, I think that this is an excellent opportunity, at a time when we are all worried about outside interference in medical care with all kinds of new and strange systems being thought of that haven't much of anything to offer us, for the State Medical Association to encourage two, three, four or five counties to go ahead on a strict limitation income basis, taking in those who cannot pay for the care of a case of pneumonia, let us say, out of income, yet they may be able to pay for it in the fall.

I spent seventeen years in private practice, and I know that every day that passed and my bills weren't paid, I rarely collected a bill past ninety days due. They just couldn't pay them. They were honest.

We have calls from these families now, for supervisors. Do you think we can stand that out of our budget? We get some letters: "My husband needs a pair of pants. They are going to cost $3.50. What is your balance?" Well, you loan these people money, and they can only spend it for the purpose for which it was loaned to them; they cannot buy an automobile, and leave the barn unpainted and the machinery rusting.

That is the proposition we are up against with the low income groups. You do not meet them very often unless they get into a jam. They are independent and the most rugged individualists in the world. But, no one in the country goes without medical care if he wants it and asks for it; however, there are a great many of them who won't ask you for it, if they cannot pay at least some of the bill.

Now, I should like to know whether the State Society, through its House of Delegates, would care to approve in principle, the continued negotiations with the county societies, and I should like to ask you to modify the agreement to include other farm families, setting an income limitation. I am in favor of the limitations. You don't want farmers with $10,000 incomes; you do need an income limitation.

My interest is to see as many medical societies undertake these things on a small and self-limited and strictly controlled basis as possible, so that when something is put up to you later on a broad basis by the State Legislature, or by Congress, you can say, as Dr. Fishbein has said: "It is not true that organized medicine is not doing its share toward stepping out into pre-payment plans. We have done it with any number of families with the Farm Security Administration, and they have been perfectly satisfied."

We also have from the A. M. A. a rousing endorsement of the way in which we have operated the plan for the county societies. They have approved our way of operations. In no case has there been a feeling on the part of the doctors of the counties that organized medicine has not had its way in every professional phase.

I believe that is about the whole story. Of course, I shall be glad to answer questions or enter into any further discussion that is necessary, if time permits.

CHAIRMAN BLISS: You have heard the proposition. You have heard Dr. Newbury ask for a vote of approval to go on with this plan and its dealings with the county medical societies.

Will some one make a motion regarding this matter, or is there any criticism of the plan?

DR. PRATT: I think this came up several years ago. The State Society expressed their willingness to the county societies to consider the matter if they wished to do so.

I would like to make a motion that repeats that as it was before.

DR. PLUMMER: I will second the motion.

CHAIRMAN BLISS: You have heard the motion, which is to the effect that the State Medical Association, through the House of Delegates, approves of this plan, and gives the county societies the right to go ahead. That is, the State Society gives the county societies a free hand to go on with their individual dealings with this plan to accept or reject it.

All those in favor of the motion will please signify by saying "aye."

There was a chorus of "ayes" and the motion was carried, unanimously.

CHAIRMAN BLISS: There are, doubtless, questions to be raised regarding this plan. For instance, I should like to ask this question. Are all persons in farm fami-

lies with an income of $3,000 a year eligible for money under this plan, to carry on medical care in Maine?

Dr. Newbury: They are by no means eligible to borrow from the government. Our families average $400.00 a year.

Chairman Bliss: Whether they borrow money or not—

Dr. Newbury: I am recommending in the vicinity of Buffalo and the seven counties that I think for farm families, the income limitation should be lower.

Chairman Bliss: Except for a very small number of families, every farm family in this state would be eligible?

Dr. Newbury: That is right; 99 per cent of them would be eligible.

Chairman Bliss: There are very few farm families outside of the potato and blueberry country whose income exceeds $3,000 a year, and $2,500 a year would be a very high average for couples; for single persons, $1,800 a year would be about right. Now, would they be eligible under the plan in Maine?

Dr. Newbury: They would as it is listed there (referring to printed forms). We brought this out for discussion as a sort of compromise. In talking this over with the doctors at Piscataquis County, there was a little bit of a feeling about how are you going to develop a plan without snooping on the person's income, and further, how are you going to tell about the various incomes?

There was a feeling that an amount might be set fairly to avoid snooping. The ultimate determination, in case one of the doctors in the society felt it was in the economically higher group, was that the person might be called upon to produce income tax returns.

However, the amount was left a little high; I personally didn't favor it that high.

Chairman Bliss: Can this be modified?

Dr. Newbury: Every county medical society can modify it.

Chairman Bliss: This, obviously, is not fitted to the income of Maine farmers, this $3,000; all but a few farmers in Maine would be eligible to this type of medical service, and in actual operation, in my neck-of-the-woods, the strangest people turn up under this plan, people who have always paid their bills and are perfectly willing to do so. One girl had a Cesarian section for $35.00 recently, and she was perfectly able to pay any sort of fee.

Now, even though we give this matter approval to go ahead with the county medical societies, this limit here does not apply to Maine. I don't know where they have such incomes, but not in Maine, that is certain. There should be some modification of those figures for the State of Maine, because a family having an income, gross or net, of $3,000 does not need this kind of help.

Dr. Plummer: Mr. Chairman, wouldn't that be within the jurisdiction of the individual county societies to take up these points?

Chairman Bliss: That may be so, but we shall not see this gentleman again, possibly, and here are the figures. They certainly do not apply to Maine. Those figures should be cut in half, at least, if not more. Those are ridiculous figures. They might apply to shipyard workers, and the fattest of them, at that, but not to Maine farmers.

Dr. Newbury: May I make three suggestions? I think it should be cut. My own feeling is that a $2,000 income for a farm family, and a pretty large family at that, is ample.

The individual county medical societies must completely disabuse their minds that this is a relief and welfare program. These people are paying the money out of their own pockets, sort of under a chattel mortgage; therefore, the prevailing fee schedule must be the one in the community. If I do my job properly, there won't be any more Cesarian operations for the $35.00 figure.

The fees charged to the families last year were 25 per cent too low to pay the doctors 100 cents on the dollar.

However, there are three factors to protect you from exploitation.

1. Reduce the income.
2. Don't give the families a break on your fees. They don't want you to change your usual ways of doing business.
3. Raise your fees.

Those three protections will make you all pretty safe.

Chairman Bliss: It is all right to submit our bills of fairly large size, but when the bills are paid, they are usually paid on a pro rata basis, and the original fee charged has no relationship whatever to the amount paid. For instance, Hancock and Washington Counties are grouped with Piscataquis and Penobscot. Penobscot walks off with this thing, and Hancock and Washington hold the bag. Those two counties have an entirely different type of farming, and they should be by themselves.

Dr. Newbury: You know what happened?

Chairman Bliss: I have some personal knowledge of what happened.

A Member: There is one thing that interests me. Who administers this thing? The Federal government?

Dr. Newbury: Not in any sense. The difficulty in this plan has been to get the local doctors to administer it themselves. There are a number of you here who sat on the committees, and met month after month. Have any of you ever received a directive or any instructions as to what you should do or charge or any thing like that, any interference in the practice of your profession? It is possible, of course. So I am just asking you that. As a matter of fact, if I had been administering this plan from Philadelphia, it would have gone on the rocks! It is going to call for more medical administration locally, because I am not going to administer it. You know perfectly well the situation that I would put myself in if I came up here and started dictating your fees.

I hope that if there are any complaints of government or any other kind of interference, that you will say so right now.

Chairman Bliss: My warning to the delegates in going back to their counties is to this text, that if this fee schedule is left as it is, families with $3,000 incomes and couples with $2,500 and individuals with $1,800, then we have already entered a type of socialized medicine, because this will include, on a guess, more than 80 per cent of the farmers outside of Aroostook County!

Now, if we are giving the approval to a pooled medical fund for any organization, regardless of what it is, we have already entered the field which we do not like.

It is perfectly right and proper to go on and give the county societies a free hand in dealing individually with the Farm Security Administration, but with that limitation, practically all the families are eligible. So that unless that is dressed up a bit, we are already on the road to the thing which we have so opposed in other avenues.

Dr. Gauvreau: In the county where I come from, we have developed through the insurance companies, the Metropolitan, and so forth, and the mills, the Pepperell Manufacturing Company, the Androscoggin Mills, etc., the group insurance plan. It is administered by the insurance companies. Why couldn't the insurance companies administer this thing rather than have it done this way?

Dr. Newbury: There is no guarantee of any services.

Chairman Bliss: It is a very different thing, the plan suggested here, than the insurance plan you have reference to.

Is there any other business to come before the meeting today? If not, a motion is in order to adjourn.

A Member: I move that we adjourn.

This motion was duly seconded and was carried.

(Whereupon, the meeting was adjourned at 10.00 o'clock in the morning.)

Correction

Proceedings, First Meeting, House of Delegates, Ninety-First Annual Session, Maine Medical Association. Remarks by Dr. Albert P. Royal, Rumford, Maine, relative to the Oxford Paper Company Welfare Committee, in the October, 1944, Journal, page 205: *Hospitalization alone, which pays 17 days,* should be changed from 17 days to 70 days.

Book Reviews

"Methods of Treatment"

By: Logan Clendening, M. D., clinical professor of medicine, Medical Department of the University of Kansas; attending physician, University of Kansas Hospitals; and Edward H. Hashinger, A. B., M. D., clinical professor of medicine, Medical Department of the University of Kansas: attending physician, University of Kansas Hospitals; attending physician, St. Luke's Hospital, Kansas City, Mo.

Eighth Edition.

Published by the C. V. Mosby Company, St. Louis. Price, $10.00.

The many features of all previous editions are retained and "something new has been added" in this eighth edition of "Methods of Treatment" by Drs. Hashinger and Clendening. New subjects include the treatment of intractable pain with cobra venom, bee venom, etc.; sciatica due to herniation of the nucleus pulposus; indications for surgery in hypertension; pneumococcic and influenzal meningitis; the Kenny treatment of poliomyelitis; vitamin K therapy in prothrombin deficiency; the new conceptions of fat metabolism and acidosis in diabetes; and the use of the newer glycosides of digitalis. The authors go into great length to discuss the new sulfa drugs, likewise the new vitamins. Sections on opium and its alkaloids, urinary antiseptics, and the treatment of intestinal parasites have been revised to bring them up to present concepts. Like previous editions, the authors have set forth in one volume their research results from widely scattered publications and findings.

"A Synopsis of Clinical Syphilis"

By: James Kirby Howles, B. S., M. D., M. M. S., professor of dermatology and syphilology, and director of the department, Louisiana State University School of Medicine; senior visiting physician, Charity Hospital of Louisiana at New Orleans; visiting physician, French Hospital, Mercy Hospital, Hotel Dieu, Southern Baptist Hospital and Touro Infirmary.

With 121 text illustrations and two color plates.

Published by the C. V. Mosby Company, St. Louis. Price, $6.00.

Although he insists his efforts are a synopsis rather than a text, Dr. Howles goes very thoroughly and intelligently into a discussion of clinical syphilis in this volume. Breaking away from usual literary form, the doctor discusses syphilis through the medium of a definite pattern, starting with a section of nine chapters on "General Considerations of Syphilis," followed by 12 chapters on "Systemic and Regional Syphilis," and concluding with four chapters on "The Familial and Public Health Aspects of Syphilis." Much can be said in behalf of Dr. Howles' efforts because he most certainly has set down facts and figures and covered his salient points with timely photographic illustrations. Numerous reading references, to elaborate rather than to augment his points, are found at the end of the book.

"Medical Care of the Discharged Hospital Patient"

By: Frode Jensen, M. D., instructor in medicine, Syracuse University College of Medicine; H. G. Weiskotten, M. D., dean and professor of pathology, Syracuse University College of Medicine; and Margaret A. Thomas, M. A. (Oxon).

Published by The Commonwealth Fund, New York. Price, $1.00.

An exhaustive survey by the Syracuse (N. Y.) University College of Medicine has produced conclusive evidence that the extension of the range of a hospital's service to include the home can, in itself, prevent numerous cases of the re-hospitalization of discharged, chronically ill patients.

And, too, it was determined, an earlier hospital discharge date can be set for medical ward patients who can show the assurance of proper home medical care.

This enlightening survey disclosed also that 90 per cent of the cost of general medical ward care at the University Hospital was for chronic illness and that only a third of the patients were receiving satisfactory medical supervision after discharge.

The authors found that hospital costs could be substantially reduced and that several hundred additional patients could be accommodated annually if the hospital carried its supervision into the home.

This book is recommended for hospital administrators, physicians, health officers, welfare leaders, and others concerned with or interested in community health.

"Shock Treatment in Psychiatry"

By: Lucie Jessner, M. D., Ph. D., resident psychiatrist, Baldpate, Georgetown, Mass.; graduate assistant in psychiatry, Massachusetts General Hospital; assistant in psychiatry, Beth Israel Hospital, Boston; and V. Gerald Ryan, M. D., associate psychiatrist, Elmcrest Manor, Portland, Conn.; assistant in psychiatry, Harvard Medical School.

With an introduction by Harry C. Solomon, M. D., clinical professor of psychiatry, Harvard Medical School.

Published by Grune & Stratton, Inc., New York. Price, $3.50.

Here is a brief, practical review on shock therapy, so-called, which gives consideration mainly to treatments with insulin, metrazol and electric current. The manual is of more than passing interest and value because "shock therapy," however distasteful processes may appear to be, results have been obtained and, in the words of Dr. Solomon, this treatment "is likely to remain with us until better methods are found."

The authors in their introductory note set forth that the text is based considerably on personal experiences and expressions of personal opinions. With this in mind, the text takes on added value because of the wide scope of practice engaged in by the two medical men.

"General Autonomic Regulations in Health and Disease"

By: Heymen R. Miller, M. D., associate attending physician, Montefiore Hospital, New York City.

With introduction by John F. Fulton, M. D., M. A., D. Phil. (Oxon), Sterling, professor of physiology, Yale University.

Published by Grune & Stratton, New York. Price, $5.50.

Aimed at offering to the profession a text dealing in the main with the central autonomic controls and their relations to clinical medicine, Dr. Miller in the vernacular has hit the so-called "jack-pot." His literary effort, based on years of observation and research, is certain to provoke widespread interest to the clinician, for whom it was written.

Dr. Miller gives prominence in his book to the part played by the cerebral cortex in bringing about the more delicate autonomic adjustments. This feature, and it is but one of many detailed discussions, doubtless will bear the closest of scrutiny from readers because he has carefully marshalled salient medical facts to give proof to his theories.

In closing chapters the author delves deeply into an anatomic discussion of the hypothalamus which in itself is a highly illuminating summation of a new and rapidly developing field.

"Encephalitis, a Clinical Study"

By: Josephine B. Neal, A. B., M. D., Sc. D., F. A. C. P., associate director, Bureau of Laboratories, Department of Health, New York; clinical professor of neurology, College of Physicians and Surgeons, Columbia University.

With a foreword by Hubert S. Howe, A. M., M. D., clinical professor of neurology, College of Physicians and Surgeons, Columbia University.

Published by Grune & Stratton, New York.

With the grave danger that the close of World War II will bring with it an epidemic of encephalitis, such as was experienced after the last world conflict, this deep-rooted text takes on new and added importance to medical men.

The author has devoted years of her life to a study of this dreaded scourge and, as executive secretary of the Matheson Commission for the Study of Epidemic Encephalitis, Dr. Neal has had under her direction more than 700 patients afflicted with this disease.

She offers in this book the results of her years of work in this field and, in addition, the text includes chapters and discussions by six collaborators, each well versed in his field.

"Simplified Diabetic Management"

By: Joseph T. Beardwood, Jr., A. B., M. D., F. A. C. P., and Herbert T. Kelly, M. D., F. A. C. P. Dr. Beardwood is associate professor of medicine, Graduate School of Medicine, University of Pennysylvania; physician to the Presbyterian Hospital in Philadelphia; physician-in-chief to Department of Metabolic Diseases, Abington Memorial Hospital, Abington, Pa., visiting physician in charge of diseases of metabolism, Bryn Mawr Hospital, Bryn Mawr, Pa., chief of the Metabolic Department, Philadelphia Hospital for Contagious Diseases. Dr. Kelly is associate in medicine, Graduate School of Medicine, University of Pennsylvania; associate physician, Presbyterian Hospital; chief, Department of Medicine, Doctors' Hospital; chairman of the Committee on Nutrition, Medical Society of the State of Pennsylvania; honorary chairman, Pennsylvania Nutrition Council.

Fourth Edition.

168 Pages. Published by J. B. Lippincott Company, Philadelphia. Price, $1.50.

The rapid advances in insulin therapy combined with the effects of war and food rationing on diabetics prompted the authors to revise earlier editions of "Simplified Diabetic Management" and to offer a fourth edition to the profession and the public at large.

Simplification of many chapters is accomplished as greater effort is devoted to those diabetics unable to secure the customary quantities, grades and type of diet necessary to combat their ailments.

Basically, as were the other three editions, this book is intended for diabetics themselves and, as the authors write, "should serve him as a guide and a daily source of reference." Many standard diets are included in the publication which should make the calculation of the diabetic's diet a simple matter.

"Minor Surgery"

Edited by: Humphrey Rolleston and Alan Moncrieff.

Published by Philosophical Library, New York. Price, $5.00.

Many of the Nation's leading surgeons, including large numbers in the Armed Services, contribute interesting chapters to "Minor Surgery."

Eighteen different chapters afford discussion and description of as many subjects including minor wounds, sprains, the feet, the hand, the mouth, the nose and throat, the ear, the eye, bursae and ganglia, tumors and cysts, skin infections, the rectum, the genito-urinary system, a non-operative treatment of hernia, varicose veins, ulcers and phlebitis, gynæcology, childhood and anæsthesia and analgesia.

Among some of the contributors are Surgeon Rear Admiral Cecil P. G. Wakeley, senior surgeon, King's College Hospital; Norman C. Lake, D. Sc., M. D., M. S., F. R. C. S., senior surgeon, Charing Cross Hospital; A. Rendle Short, B. Sc., M. D., B. S., F. R. C. S., professor of surgery, University of Bristol; and C. Langton Hewer, M. B., B. S., D. A., senior anæsthetist, St. Bartholomew's Hospital, London.

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